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
HEALTH BENEFITS PLAN

Computer Matching Agreement No. 2016-08
Department of Health and Human Services No. 1605

Effective Date - April 2, 2016
Expiration Date - October 2, 2017

I. PURPOSES, LEGAL AUTHORITIES, AND DEFINITIONS

A. Purposes

This Computer Matching Agreement (Agreement) by and between the Centers For Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) and the Veterans Health Administration (VHA) (each a Party, and collectively, the Parties) establishes the terms, conditions, safeguards, and procedures under which VHA will provide records, information, or data ("data") to CMS under 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) (collectively, the ACA). VHA acknowledges that CMS will use VHA data to make initial Eligibility Determinations for Verification of Eligibility for Minimum Essential Coverage under the ACA through a Veterans Health Administration Health Benefits Plan. In CMS' Capacity as the Federally-Facilitated Exchange (FFE) and when HHS determines eligibility pursuant to 45 C.F.R. § 155.302, and VHA further acknowledges that Administering Entities (AE), which include State-based Exchanges, will use VHA data, accessed through CMS Data Services Hub (Hub), to make Eligibility Determinations. VHA acknowledges that AEs, which include State-based Exchanges and Basic Health Programs, will use VHA data, accessed through Data Services Hub (Hub), to make Eligibility Determinations. CMS acknowledges that it will enter into separate agreements with State-based Administering Entities that are consistent with the terms and conditions set forth in this Agreement and with VHA's requirements in administering this matching program.

Data will be matched for the purpose of assisting CMS or State-based Exchanges to determine eligibility for the following benefits: (1) an APTC under 26 U.S.C. § 36B and

section 1412 of the ACA; and (2) a CSR under Section 1402 of the ACA. Specifically, CMS will use VHA data to verify an Applicant or Enrollee's enrollment for VHA Health Care Program which constitutes minimum essential coverage (MEC) as defined in section 5000A(f) of the Internal Revenue Code of 1986, 26 U.S.C. §5000A, as amended by §1501 of the ACA, and its implementing regulations.

The Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law 100-503) amended the Privacy Act (5 U.S.C. §552a) and 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 status verification checks to be conducted by the Hub and FFE using the Enrollment System's Administrative Data Repository (ADR) and Enrollment Database (DBA) and the Claims Processing & Eligibility Database (CP&E) constitute a "computer matching program" as defined in the CMPPA.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the Recipient Agency, and as such, is responsible for publishing the Federal Register notice required by 5 U.S.C. § 552a(e)(12). The VHA component responsible for the disclosure of information is the VHA Privacy Office Manager, Information Access and Privacy Office. VHA will serve as the Source Agency in this Agreement.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein and the applicable law and implementing regulations. The terms and conditions of this Agreement will be carried out by authorized employees and contractors of CMS and VHA.

B. Legal Authorities

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

1. This Agreement is executed pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a) as amended by the CMPPA, and the regulations and guidance promulgated thereunder; the Office of Management and Budget (OMB) Circular A-130, "Management of Federal Information Resources" published at 61 Federal Register (Fed. Reg.) 6428 (February 20, 1996); and OMB guidelines pertaining to computer matching published at 54 Fed. Reg. 25818 (June 19, 1989). The following statutes provide legal authority for the uses, including disclosures, under this Agreement:
2. As part of the reforms of the health care system under the ACA, certain individuals will be eligible for certain financial assistance in paying for private insurance coverage under a Qualifying Health Plan (QHP) when enrollment is through an Exchange. Such assistance includes APTCs, under 26 U.S.C. § 36B and section 1412 of the Affordable Care Act, and CSRs under section 1402 of the Affordable Care Act. Pursuant to 26 U.S.C. § 36B(c)(2), one of the eligibility requirements for APTC is that the individual is not eligible for MEC as defined in 26 U.S.C. § 5000A(f), such as the coverage under VHA Health Care Programs. Under 26 C.F.R. § 1.36B-2(c)(2)(iii), "[a]n individual is eligible for minimum essential coverage under a health care program under chapter 17 or 18 of Title 38, U.S.C. only if the individual is

enrolled in a health care program under chapter 17 or 18 of Title 38, U.S.C. identified as minimum essential coverage in regulations issued under section 5000A." Section 1402(f)(2) of the ACA provides that an individual is ineligible for CSRs if the individual is not also eligible for the premium tax credit for the relevant month.

3. Section 1411 of the ACA requires the Secretary of HHS to establish a program to determine eligibility for an individual to purchase a QHP through an Exchange and eligibility for eligibility for APTC and CSRs. Under 45 C.F.R. §§ 155.302 and 155.305, the eligibility determinations for APTCs and CSRs may be made by an Exchange or HHS. CMS carries out Exchange-related responsibilities of HHS. 76 Fed. Reg. 4703 (Jan. 26, 2011). The system established by HHS under § 1411 to determine eligibility for APTCs and CSRs, requires an Exchange to verify whether an individual is eligible for certain Minimum Essential Coverage, such as coverage under a VHA Health Care Program, by sending information to HHS for HHS to provide the response. 45 CFR § 155.320(b).
4. Pursuant to section 1411(c)(4)(B) and 1411(d), the Secretary of HHS has determined that verification of eligibility for the VHA coverage described in this Agreement is best made using a computer matching program as described in this Agreement. An Exchange may use this verification service through the Hub to support eligibility determinations for APTC and CSRs by sending a request to the Hub. CMS facilitates the verification against VHA data, and a response with the result of that verification attempt is sent to the entity that determines eligibility for APTC and CSRs. Under 45 C.F.R. §§ 155.302 and 155.305, the eligibility determinations for APTC and CSRs may be made by an Exchange or HHS. CMS carries out the Exchange-related responsibilities of HHS (76 Fed. Reg. 4703 (Jan. 26, 2011)).After the verification is made, the verification is sent to the entity that determines eligibility for APTCs and CSRs.
5. Under the authority of sections 1311, 1321, and 1411(a) of the ACA, the Secretary of HHS adopted the regulation at 45 C.F.R. § 155.330, which further addresses 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.
6. 5 U.S.C. 552a(b)(3) authorizes a Federal agency to disclose information from its system of records, without prior written consent, when such disclosure is pursuant to a routine use. The uses and disclosures under this agreement are covered under routine use (RU) #14 in the VHA system of records, 147VA16, Enrollment and Eligibility Records (VA); RU #25 in the VHA system of records, 54VA16 Health Administration Center Civilian Health Medical Record – VA (CHAMPVA), and Spina Bifida Healthcare Program; and RU #3 in the CMS system of records, Health Insurance Exchanges Program (HIX), CMS System No. 09-70-0560, as amended.
7. Health plans are only permitted to use or disclose protected health information (PHI), such as eligibility and enrollment information, as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Among other things, the HIPAA Privacy Rule (45 C.F.R. § 164.512(k)(6)(i)) permits a health plan that is a government program providing public benefits, such as a VHA Health Care Program, to disclose eligibility and enrollment information to an agency

administering another government program providing public benefits if the disclosure is required or expressly authorized under regulation or statute. 45 C.F.R. § 155.320(b)(2) expressly authorizes the disclosure to HHS of information regarding eligibility for and enrollment in a health plan, which may be considered PHI, for the purposes of verification of an applicant's eligibility for Minimum Essential Coverage as part of the eligibility determination process for APTC or CSRs.

C. Definitions

1. "ACA" 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) (collectively, the ACA);
2. "Agent" or "Broker" means a person or entity licensed by the State as an agent, broker or insurance producer;
3. "Applicant" means an individual who is seeking eligibility for him or herself for APTCs and/or CSRs in connection with private insurance coverage under a QHP through an application submitted to an Exchange, or enrollment in a BHP;
4. "APTC" of "Advanced Premium Tax Credit" means payment of the tax credits specified in section 36B of the Internal Revenue Code of 1986 (as added by section 1401 of the Affordable Care Act) 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 the Affordable Care Act;
5. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 C.F.R. § 155.227, on behalf of an Applicant or Enrollee in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange;
6. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
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. Claims Processing & Eligibility Database (CP&E) is a database managed by the VHA;
9. "CMS" means the Centers for Medicare & Medicaid Services;
10. "Cost-Sharing Reduction" or "CSR" means cost sharing reductions, which are available under 42 U.S.C. § 18071 for an eligible individual enrolled in a silver level plan through an Exchange or for an individual who is an Indian enrolled in a QHP through an Exchange;
11. "Eligibility Determination" means the determination of eligibility for APTC and CSRs, including a redetermination based on a self-reported change pursuant to 45 C.F.R. § 155.330, and the process of appealing a decision on a determination when an appeal is provided pursuant to section 1411(f) of the Affordable Care Act;

12. “Enrollee” means an individual enrolled in a QHP through an Exchange;
13. Enrollment System’s Administrative Data Repository (ADR) and Enrollment Database (DBA) are databases managed by VHA;
14. “Exchange” means an American Health Benefit Exchange established under sections 1311(b), 1311(d)(1), or 1321(c)(1) of the ACA, including both State-based Exchanges and FFE;
15. “FFE” or “Federally-facilitated Exchange” means an Exchange established by HHS and operated by CMS under Section 1321(c)(1) of the ACA;
16. “HHS” means the Department of Health and Human Services;
17. “Hub” or “Data Services Hub” is the CMS managed, single data exchange for Federal and State-based Exchanges to interface with Federal agency partners. Hub services allow for adherence to Federal and industry standards for security, data transport, data safeguards as well as CMS policy for Exchanges for eligibility determination and enrollment services;
18. “MEC” or “Minimum Essential Coverage” is defined in I.R.C. § 5000A(f) and includes health insurance coverage offered in a qualified health plan and provided 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 (as defined in Section III.22);
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 C.F.R. § 155.210;
20. “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 their name, social security number, 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.;
21. “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 Code of Federal Regulations issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 in title 45 of the Code of Federal Regulations;
22. “Record” 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;
23. “Security Incident” means 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. "VHA Health Care Program" means a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of 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 may request verification from VHA of an Applicant or Enrollee's enrollment status in a VHA Health Care Program, which is a form of Minimum Essential Coverage under the ACA; CMS will only request data from VHA's records when necessary to make an Eligibility Determination.
3. CMS will provide to VHA the required data elements necessary and agreed upon by both Parties when requesting data from VHA through the CMS Hub, including, but not limited to, First and Last Name, Gender, Date of Birth and SSN.
4. CMS 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 a State-based Exchange can request and receive information from VHA through the CMS Hub to make Eligibility Determinations.
6. CMS will enter into agreements with State-based Exchanges that bind the State-based Exchanges to comply with appropriate privacy and security protections for PII, including requirements for Exchanges and their employees, contractors, and agents to comply with the privacy and security requirements set forth in 45 C.F.R. § 155.260.
7. CMS will provide Congress and the OMB with notice of this matching program and will publish the required matching notice in the Federal Register.

B. VHA Responsibilities

1. VHA will develop procedures to respond to verification requests by CMS to transmit information from DEERS to verify or validate eligibility for 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 Programs within the period requested by CMS or a State-based Exchange 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. Justification

As part of the reforms of the health care system under the Affordable Care Act, certain individuals will be eligible for APTC and CSRs. Pursuant to 26 U.S.C. § 36B(c)(2) and section 1402(f)(2) of the ACA, one of the eligibility requirements for APTC and CSRs is that the individual is not eligible for Minimum Essential Coverage (MEC), such as the coverage provided through the Veterans' Health Administration described in more detail elsewhere in this Agreement.

The Affordable Care Act requires the use of a single, streamlined application, which may be used to apply for eligibility for APTC and CSRs and other benefits, such as enrollment in a QHP through an Exchange and Medicaid. An Applicant or Enrollee must be able to file this application online, by telephone, in person or by mail with any of the entities administering these programs. The ability of an Applicant or Enrollee to access the appropriate coverage and financial assistance, such as APTC and CSRs, across multiple programs through a single streamlined application and coordinated eligibility process means that no matter how an application is submitted or which program receives the application data, an Applicant or Enrollee will experience a consistent process and receive a consistent Eligibility Determination, without the need to submit information to multiple programs.

In order to provide accurate and efficient Eligibility Determinations when an Applicant or Enrollee uses this single streamlines application and coordinated eligibility process, a computer matching program is necessary because it provides an efficient and prompt means to verify whether one of the criteria for eligibility for APTC and CSRs, namely not being enrolled in a VHA Health Program, is met.

B. Anticipated Results

CMS anticipates that this data match will produce expedited Eligibility Determinations and will minimize administrative burdens. The benefit of this data match with respect to the Exchange program is the increased assurance that CMS achieves efficiencies and administrative cost savings for the programs administered by Administering Entities. This collaborative model, which offers service-based access to authoritative data, will lessen financial and administrative burdens by eliminating the need for each State to execute several agreements with multiple federal agencies.

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. The authority to conduct the matches described in this Agreement is derived from the authorities listed in Section II of this Agreement.

IV. DESCRIPTION OF THE DATA TO BE EXCHANGED

The Privacy Act requires that each Computer Matching Agreement for protected data specify a description of the records which will be matched and exchanged, including a sample of data

elements 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 Notice (SORN) that supports this data matching program is the Health Insurance Exchanges Program (HIX), CMS System No. 09-70-0560, as amended, first published at 78 Federal Register, 8538, February 6, 2013. Routine Use 3 supports CMS's disclosure to VHA.
2. VHA maintains the following SORNs to support this data matching program:
   a. Routine Use #14 in 147VA16 Enrollment and Eligibility Records (VA); published at 74 Federal Register 44901, August 31, 2009; and
   b. Routine Use #25 in 54VA16 Health Administration Center Civilian Health Medical Record – VA (CHAMPVA), and Spina Bifida Healthcare Program published at 74 Federal Register 34398, July 15, 2009.

B. Specified Data Elements.

1. From CMS to VHA. For each Applicant or Enrollee seeking an Eligibility Determination at an Exchange, and for whom VHA has the authority to release information, the Exchange will submit a request through the CMS 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 (optional)
   f. SSN (required)
   g. Requested QHP Coverage Effective Date (required)
   h. Requested QHP Coverage End Date (required)
   i. Transaction ID (required)
2. From VHA to CMS. For each Applicant or Enrollee seeking an Eligibility Determination at an Exchange, from whom CMS has secured consent and VHA has the authority to disclose information, VHA will provide a response to the CMS 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 VA's record contains a Date of Death, VA 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 (as defined in section III).

C. Number of Records.

The following table provides the base estimates for the total number of transactions in FY 2016 and FY 2017, as well as the number of transactions in the estimated highest month within each of those years. 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
Base Estimate	90,794,949	10,115,822	114,473,371	12,587,959

V. PROCEDURES FOR INDIVIDUAL NOTICE

A. CMS will publish notice of the matching program in the Federal Register as required by the Privacy Act (5 U.S.C. § 552a(e)(12)).

B. At the time of application or change of circumstances, an Exchange will provide a notice to Applicants or Enrollees on the OMB-approved streamlined eligibility application. At renewal the Exchange will provide a renewal notice, pursuant to 45 C.F.R. § 155.335. These notices will provide information that the eligibility status of each Applicant or Enrollee may be verified by matching against VHA records.

VI. VERIFICATION AND OPPORTUNITY TO CONTEST

The Privacy Act requires that each matching agreement specify procedures for verifying information produced in the matching program and an opportunity to contest findings, as required by 5 U.S.C. § 552a(p).

A. Verification and Opportunity to Contest Procedures.

Before an Exchange may take any adverse action based on the information received from the match, the Applicant or Enrollee will be permitted to provide the necessary information or documentation to verify eligibility information. When an Exchange determines that an individual is ineligible for APTC or CSRs based on the information provided by the match (which is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee), the Exchange will comply with applicable law and will notify each Applicant, or Enrollee of the match findings and provide the following information: (1)The Exchange received information that indicates the individual is ineligible for APTC or CSRs; 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 APTC or CSRs.

VII. ACCURACY ASSESSMENTS

VHA currently estimates that 99% of the information within the ADR is accurate for ACA purposes in cases where 1) an exact applicant match is returned, and 2) the applicant has an enrollment status of "verified", and 3) their enrollment period coincides with the start/end dates received from the Hub.

VIII. PROCEDURES FOR RETENTION AND TIMELY DESTRUCTION OF IDENTIFIABLE RECORDS

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 all such data by electronic purging, unless VHA or CMS are required to retain the information for enrollment, billing, payment or program audit purposes. The CMS FFE and State-based Exchanges will retain data for such purposes. In case of such retention, VHA and CMS will retire the retained data in their systems of records in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). VHA and CMS will not create permanent files or separate system comprised solely of the data provided by the other agency.

IX. SECURITY PROCEDURES

A. 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.

B. Legal Compliance. CMS and VHA shall 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 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. Additionally, CMS will follow Federal, HHS, and CMS policies including all applicable publications, the HHS Information Systems Program Handbook, and the CMS Information Security Handbook.

   CMS and VHA 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) 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.

C. 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.

D. Loss, Potential Loss, Incident Reporting, and Breach Notification. CMS and VHA will comply with OMB reporting guidelines in the event of a loss, potential loss, Security Incident, or Breach of PII (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)). 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 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:

- VA Network and Security Operations Center (NSOC) 1-800-877-4328; VHA IT Service Desk: 303-398-7123; or
- E-mail: HACTSTCustomerSupport@va.gov
- CMS IT Service Desk: 410-786-2580
- E-mail: 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. 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.

E. 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., Exchanges 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.

F. 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.

G. 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.

H. Application of Policies and Procedures. The Parties will adopt policies and procedures to ensure that each Party uses the information described in this Agreement that is contained in their respective records or obtained from each other solely as provided in this Agreement. CMS and VHA will comply with their respective policies and procedures and any subsequent revisions.

I. On-Site Inspections. Each party has the right to monitor the other party's compliance with FISMA and OMB M-06-16 requirements for data exchanged under this Agreement, and to audit compliance with this Agreement, if necessary, during the lifetime of this Agreement, or any extension of this Agreement. Each party will provide the other party with any reports and/or documentation relating to such inspections at the other party's request. Each party may request an on-site inspection in addition to requesting reports and/or documentation.

J. Compliance. CMS must ensure information systems and data exchanged under this matching agreement are compliant with CMS guidance Minimum Acceptable Risk Standards for Exchanges – (MARS-E) Exchange Reference Architecture Supplement.

X. RECORDS USAGE, DUPLICATION, AND DISCLOSURE

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

A. CMS and VHA will not use or disclose the data for any purpose other than the purposes described in this agreement or required by Federal law, without the consent of the other party. VHA and CMS will not give such permission, unless the law requires 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.

B. CMS and VHA will not use the data to extract information concerning individuals therein for any purpose not specified by this Agreement or allowed by applicable SORNs or Federal law.

C. The matching data provided by VHA under this Agreement will remain the property of VHA and will be retained by CMS to be used for internal audits to verify the accuracy of matches and to adjudicate appeals. VHA matching data will only be destroyed after match activity, appeals and audits involving the data have been completed as described under this matching program.

D. CMS will restrict access to data solely to officers, employees, and contractors of CMS and State-based Exchanges.

E. CMS FFE 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 the FFE. The FFE 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 the Exchange 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 C.F.R. §155.260; 42 C.F.R. §431, subpart F, including §§431.301, 431.302, 431.303, 431.305; 42 C.F.R.§ 435.945; and 42 CFR 457.1110.)

F. Officers, employees, and contractors of the Parties who knowingly and willfully use or disclose information obtained pursuant to this Agreement in a manner or for a purpose not authorized by 45 C.F.R. §155.260 and § 1411(g) of the ACA are subject to the civil penalty provisions of § 1411(h)(2), which carries a fine of up to $25,000.

XI. COMPTROLLER GENERAL ACCESS

Pursuant to 5 U.S.C. § 552(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. REPORT TO CONGRESS AND OMB

When both HHS Data Integrity Board (DIB) and the VHA DIB have approved 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 VHA.

XIII. REIMBURSEMENT

All work performed by CMS for all costs that CMS charges VHA to perform the computer match in accordance with this Agreement will be performed on a reimbursable basis. VHA will allocate sufficient funds annually for this project. The legal authority for transfer of funds 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 VA will execute and maintain a separate Interagency Agreement on an annual basis to address CMS reimbursement of relevant VA transactional costs

related to requests covered by this Agreement. Furthermore (1) CMS will pay VHA on a transactional basis; (2) CMS will attach a tracking identifier to the finder file so that VHA can accurately bill CMS; (3) CMS agrees not to process requests directly received from any non-profit entity that VHA does not have the legal authority to bill.

XIV. PERSONS TO CONTACT

A. The VHA contacts are:

1. Project Coordinator

   Mike Davis
   IT Program Manager
   Systems Management
   Chief Business Office
   U.S. Department of Veterans Affairs
   BB: 202-487-3873
   Mike.Davis2@va.gov

2. Privacy Issues

   Andrea Wilson
   VHA Privacy Office Manager
   Information Access and Privacy Office
   Phone: 321-205-4305
   Andrea.Wilson3@va.gov

3. Systems Security Issues

   Adrienne Ficchi
   Director, Health Care Security Requirements
   Health Information Governance
   Phone: 215-823-5826
   Adrienne.Ficchi@va.gov

B. The CMS contacts are:

1. Program Issues:

   Elizabeth Kane
   Director, Verifications Policy and Operations Branch
   Eligibility and Enrollment Policy and Operations
   Center for Consumer Information and Insurance Oversight
   Centers for Medicaid and Medicare Services
   Phone: (301) 492-4418
   E-Mail: Elizabeth.Kane@cms.hhs.gov

2. Systems Operations:

   Darrin V. Lyles
   Information Security Officer, RPDG
   CMS\OIS\RPDG
   Consumer Information and Insurance Systems Group
   7500 Security Boulevard

Baltimore, MD 21244
Phone: 410-786-4744
Phone: 443-979-3169 (Mobile)
E-mail: Darrin.Lyles@cms.hhs.gov

3. Security Issues:

Devany Nicholls
Baltimore Data Center ISSO
Division of Operations Management
Enterprise Infrastructure & Operations Group
Office of Technology Solutions
7500 Security Boulevard
Baltimore, MD 21244-1859
Phone: (410) 786-8189
Fax: (410) 786-9700
E-mail: Devany.Nicholls@cms.hhs.gov

4. Privacy and Agreement Issues:

Walter Stone
CMS Privacy Officer
Division of Information Security, Privacy Policy & Governance
Offices of Enterprise Management
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: N1-24-08
Baltimore, MD 21244-1849
Telephone: 410-786-5357
Fax: 410-786-1347
E-mail: walter.stone@cms.hhs.gov

5. Privacy Incident Reporting:

LaTasha Grier
Division of Cyber Threat & Security Operations
Division of Information Security, Privacy Policy & Governance
Information Security & Privacy Group
Office of Enterprise Information
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: N1-24-08
Baltimore, MD 21244-1849
Telephone: (410) 786-3328
E-mail: LaTasha.Grier@cms.hhs.gov

XV. EFFECTIVE DATE, TERM, MODIFICATION, AND TERMINATION

A. Effective Date: The Effective Date of this Agreement is April 2, 2016, provided that the following review periods have lapsed: thirty (30) days from the date CMS publishes a Notice of Computer Matching in the Federal Register; thirty (30) days from the date the

matching program report is transmitted to the Congressional committees of jurisdiction consistent with the provisions of 5 U.S.C. §§ 552a (r), (o)(2)(A), and (o)(2)(B); and forty (40) days from the date the matching program report is sent to OMB, consistent with the provisions of 5 U.S.C. § 552a (r) and OMB Circular A-130, Revised (Transmittal Memorandum No. 4), November 28, 2000, Appendix I, entitled "Federal Agency Responsibilities for Maintaining Records about Individuals" (A-130 Appendix I).

B. Term: This initial term of this Agreement will be eighteen (18) months.

C. Renewal: The DIBs of CMS and VHA 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 VHA can certify the following to their DIBs:

1. The matching program will be conducted without change; and
2. CMS and VHA have conducted the matching program in compliance with the original agreement.

If either agency does not want to extend this Agreement, it should notify the other at least ninety (90) days prior to the expiration of this 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 VHA.

E. 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 will be effective ninety (90) days after the date of the notice, or at a later date specified in the notice.

XVI. 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.

XVII. DISPUTE RESOLUTION

CMS and VHA will resolve disputes related to this Agreement in accordance with instructions provided in the Treasury Financial Manual (TFM) Volume I, Part 2, Chapter 4700, Appendix 10, *Intragovernmental Transactions Guide*, available on the TFM Website at http://tfm.fiscal.treasury.gov/v1/p2/c470.pdf.

XVIII. 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.

XIX. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

The authorized program 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 her respective 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:_____

B. Centers for Medicare & Medicaid Services Program Official

The authorized program 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 Program Official)

_____

Timothy Hill
Deputy Director
Information Security and Privacy Group
Centers for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Date:_____

C. Centers for Medicare & Medicaid Services Approving Official

The authorized program 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)

_____

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

Date:_____

D. VHA Approving Official

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 VHA Approving Official)

_____

Lynne Harbin
Deputy Chief Business Officer, Member Services
Health Eligibility Center, Chief Business Office (HEC/CBO)
Veterans Health Administration
Department of Veterans Affairs

Date:_____

E. Data Integrity Board: Department of Health and Human Services

The authorized Data Integrity Board 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 HHS DIB Approving Official)

_____

Colleen Barros
Chairperson, HHS Data Integrity Board
Acting Assistant Secretary for Administration
U.S. Department of health and Human Services

Date:_____

F. Data Integrity Board: VHA

The authorized Data Integrity Board 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 VHA DIB Approving Official)

_____

Stephen W. Warren
Acting Chairperson
Data Integrity Board
Department of Veterans Affairs

Date:_____

Attachment A: Proposed Federal Register Notice
Attachment B: Proposed Master Cost Benefit Analysis (CBA)

ATTACHMENT A

Billing Code: 4120-03

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
HEALTH BENEFITS PLAN

Computer Matching Agreement No. 2016-08
Department of Health and Human Services No. 1605

Effective Date - April 2, 2016
Expiration Date - October 2, 2017

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS)

ACTION: Notice of Computer Matching Program (CMP)

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, this notice announces the establishment of a CMP that CMS plans to conduct with the Department of Veterans Affairs, Veterans Health Administration.

EFFECTIVE DATES: Comments are invited on all portions of this notice. Public comments are due 30 days after publication. The matching program will become effective no sooner than 40 days after the report of the matching program is sent to the Office of Management and

Budget (OMB) and Congress, or 30 days after publication in the *Federal Register*, whichever is later.

ADDRESS: The public should send comments to: CMS Privacy Officer, Division of Security, Privacy Policy and Governance, Information Security and Privacy Group, Offices of Enterprise Information, CMS, Room N1-24-08, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9:00 a.m. - 3:00 p.m., Eastern Time zone.

FOR FURTHER INFORMATION CONTACT: Elizabeth Kane, Director, Verifications Policy and Operations Branch, Eligibility and Enrollment Policy and Operations, Center for Consumer Information and Insurance Oversight, Centers for Medicaid & Medicare Services, Mail Stop: AR-19-45, Phone: (301) 492-4418 or E-Mail: Elizabeth.Kane@cms.hhs.gov

SUPPLEMENTARY INFORMATION: The Computer Matching and Privacy Protection Act of 1988 (Public Law (Pub. L.) 100-503), amended the Privacy Act (5 U.S.C. § 552a) by describing the manner in which computer matching involving Federal agencies could be performed and adding certain protections for individuals applying for and receiving Federal benefits. Section 7201 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) further amended the Privacy Act regarding protections for such individuals. The Privacy Act, as amended, regulates the use of computer matching by Federal agencies when records in a system of records are matched with other Federal, state, or local government records. It requires Federal agencies involved in computer matching programs (CMP) to:

1. Negotiate written agreements with the other agencies participating in the matching programs;
2. Obtain the Data Integrity Board approval of the match agreements;
3. Furnish detailed reports about matching programs to Congress and OMB;
4. Notify applicants and beneficiaries that the records are subject to matching; and,
5. Verify match findings before reducing, suspending, terminating, or denying an individual's benefits or payments.

This matching program meets the requirements of the Privacy Act of 1974, as amended.

Date _____ _____

Walter Stone

CMS Privacy Officer

Centers for Medicare & Medicaid Services

CMS Computer Match No. 2016-07

HHS Computer Match No. 1605

Name: "Computer Matching Agreement between the Department of Health and Human Services, Centers for Medicare & Medicaid Services and the Computer Matching Agreement between the Department of Health and Human Services Centers for Medicare & 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 Health Benefits Plan."

SECURITY CLASSIFICATION:

Unclassified

PARTICIPATING AGENCIES:

Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), and the Department of Veterans Affairs, Veterans Health Administration.

AUTHORITY FOR CONDUCTING MATCHING PROGRAM:

Sections 1411 and 1413 of the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, the ACA) require the Secretary of HHS to establish a program for applying for and determining eligibility for advance payments of the premium tax credit and cost sharing reductions and authorize use of secure, electronic interfaces and an on-line system for the verification of eligibility.

The Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law100-503), amended the Privacy Act (5 U.S.C. § 552a) and requires the parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching will be conducted. CMS has determined that status verification checks to be conducted by the CMS Data Services Hub (Hub) and Federally-facilitated Exchange (FFE) using the data source provided to CMS by VHA constitute a "computer matching program" as defined in the CMPPA.

PURPOSE(S) OF THE MATCHING PROGRAM:

The purpose of the Computer Matching Agreement is to establish the terms, conditions, safeguards, and procedures under which DoD will provide records, information, or data to CMS for making eligibility determinations for advance payments of the premium tax credit (APTC) and cost sharing reductions (CSR). The data will be used by CMS in its capacity as a Federally-facilitated Exchange, and by State-based Exchanges that will receive the results of verifications using OPM data obtained through the CMS Data Services Hub.

Data will be matched for the purpose of assisting CMS or a State-based Exchange to determine eligibility for the following benefits: (1) APTC under 26 U.S.C. § 36B and (2) CSR under Section 1402 of the ACA. Specifically, CMS will use OPM data to verify an Applicant or Enrollee’s eligibility for OPM health care programs that constitute minimum essential coverage as defined in section 5000A(f) of the Internal Revenue Code of 1986, 26 U.S.C. §5000A, as amended by §1501 of the ACA.

DESCRIPTION OF RECORDS TO BE USED IN THE MATCHING PROGRAM:

The CMP will be conducted with data maintained by CMS in the Health Insurance Exchanges (HIX) Program, CMS System No. 09-70-0560, as amended. The system is described in System of Records Notice (SORN) published at 78 Federal Register (Fed. Reg.) 63211 (Oct. 23, 2013).

The CMP also will be conducted with data maintained in a VHA system of records. The VHA system of records for this matching program is titled "Enrollment and Eligibility Records (VA) (147VA16); published at 74 Federal Register (FR) 44901, August 31, 2009 under Routine Use #14; and the Health Administration Center Civilian Health Medical Record – VA (CHAMPVA)(54VA16) using Routine Use #25, and Spina Bifida Healthcare Program published at 74 FR 34398, July 15, 2009 using routine use No. 13.

INCLUSIVE DATES OF THE MATCH:

The CMP will become effective no sooner than 40 days after the report of the matching program is sent to OMB and Congress, or 30 days after publication in the *Federal Register*, whichever is later. The matching program will continue for 18 months from the effective date and may be extended for an additional 12 months thereafter, if certain conditions are met.

ATTACHMENT B

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 (QHPs) with or without advance payments of the premium tax credit or cost-sharing reductions; in Medicaid; in CHIP; or in Basic Health Plans. 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 qualified health plan through an Exchange or certain state health subsidy programs[1], 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 the Social Security Administration, the Department of Homeland Security, 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 CMAs with each of the following federal agencies: Social Security Administration (SSA), Department of Homeland Security (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

[1] 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.

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 certain data to perform verifications related to Basic Health Programs if the state administers a basic health program). 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 Trusted Data Sources without each Administering Entity having to execute separate CMAs with each Trusted Data Source. 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 Basic Health Program) 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 the 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 the 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 effect 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 a 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 Basic Health Programs) 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 Basic Health Program. 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 computer

matching agreements. 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 directly supporting 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 these 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: Although no data was developed regarding costs to third parties, we would expect that overall the increased accuracy of data matches achieved through this computer matching agreement would result in lower personnel costs to third parties. For example Navigators who assist consumers with an applicant, would have lower costs than they would with 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) costs associated with the computer matching program to recipient agencies (including State-based Marketplaces, Medicaid/CHIP agencies and Basic Health Programs) 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. This cost includes both system and personnel cost, because while a manual process to review and verify consumer information would derive most of its cost from personnel, systems would likely still exist – including a consumer account system and 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 Data Services 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%) verses 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 Basic Health Programs. For example, real-time capabilities mean the front-end application can be responsive in real time to the consumer input as well as the data received to correct data and/or reduce the need for manual follow-up. Specific examples of this efficiency could include a "prompt" to an applicant to check their social security number if it does not 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 DHS 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 what appear to be data inconsistencies. Finally, we believe this computer matching program deters fraud and abuse on applications for state health subsidy programs, further 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 approximation 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 Basic Health Programs, 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, given 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 agreement. 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 of Marketplaces providing data to support IRS's reconciliation, annual and monthly reporting is not an activity covered in the IRS-CMS CMA 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.