Office of the Secretary

Office of the Chief Information Officer

Assistant SecretaryforAdministration

Washington, DC 20201

# 2023 Department of Health and Human Services (HHS)

# Annual Computer Matching Report

## **Current Composition of the HHS Data Integrity Board (DIB)**

### Names and positions of the members of the DIB

* Cheryl R. Campbell, Chairperson and Voting Member, Assistant Secretary for Administration
* William H. Holzerland, Mandatory Voting Member, Deputy Agency Chief FOIA Officer (carries out Privacy Act responsibilities for the HHS SAOP)
* Christi A. Grimm, Mandatory Voting Member, Principal Deputy Inspector General
* Samantha Keck, Non-voting Advisory Member, Assistant Deputy Associate General Counsel

### Name and Contact Information of the DIB Secretary

Jacqlyn Smith-Simpson

200 Independence Ave., SW

Washington, D.C. 20201

Jacqlyn.Smith-Simpson@hhs.gov, (202) 795-7648

### Any Changes in Membership or Structure of the DIB

N/A

## **Matching Agreements HHS Entered Into in 2023**

### CMA HHS #2301

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) is the recipient agency and Social Security Administration (SSA) is the source agency.

**Title:** “Determining Enrollment or Eligibility for Insurance Affordability Programs under the Patient Protection and Affordable Care Act”

**Description:** This matching program enables CMS to compare Health Insurance Exchanges (HIX) Program data about Qualified Health Plan applicants and enrollees (and other individuals seeking eligibility determinations through the Exchanges) to SSA data, to confirm the individuals’ 1) identity and citizenship, 2) status as deceased or imprisoned, and 3) Title II disability benefit quarters of coverage and monthly and annual income, for the purpose of determining the individuals’ eligibility to enroll in a Qualified Health Plan through an Exchange established under the Patient Protection and Affordable Care Act (PPACA) and eligibility for Insurance Affordability Programs and certifications of exemption from the shared responsibility payment; and for the purpose of making eligibility redeterminations and renewal decisions, including appeal determinations.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-ssa-cma-2301.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.**  A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2302

**Participant Agencies:** HHS’s Administration for Children and Families (ACF) as the source agency and the Social Security Administration (SSA) as the recipient agency.

**Title:** “Title II-OCSE Quarterly Match Agreement”

**Description:** This matching program assists SSA in administering the Title II Disability Insurance (DI) program, by providing SSA with quarterly wage data (and, if legally required, unemployment insurance data) about DI applicants and recipients (clients), from OCSE’s National Directory of New Hires (NDNH). SSA uses the data to identify clients who are working and earning wages, so that SSA can make correct DI entitlement determinations, calculate correct DI payment amounts, and avoid and recover DI overpayments.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/acf-ssa-cma-2302-matching-agreement.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, based on the last cost benefit analysis prepared, described below.

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** Yes. For FY 2021, this matching operation resulted in an estimated overall savings of about $104,190,336. The total costs are approximately $6,666,804. These savings to the United States Treasury make this matching operation cost effective with a benefit to cost ratio of 15.6:1; therefore, this match is cost effective. SSA performed a cost-benefit analysis which demonstrates that $6,666,804 in costs were incurred and $104,190,336 in overpayments were avoided, based on 118,993 cases measured in FY 2021 of which 10,728 were determined to have an overpayment which would have continued undetected for at least 8 months without the matching program, resulting in a favorable benefit-to-cost ratio of 15.6:1.

### Data Exchange Memorandum of Agreement (MOU) HHS #2303

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the Department of Homeland Security (DHS) as the source agency.

**Title:** "Verification of United States Citizenship and Immigration Status Data for Eligibility Determinations"

**Description:** This matching program provides CMS’ Health Insurance Exchanges (HIX) Program with immigrant, nonimmigrant, and naturalized or derived citizen status information from USCIS’s SAVE program about Qualified Health Plan applicants and enrollees (and other individuals seeking eligibility determinations through the Exchanges), for the purpose of assisting CMS and State Administering Entities in determining the individuals’ eligibility to enroll in a Qualified Health Plan through an Exchange established under the Patient Protection and Affordable Care Act (PPACA) or eligibility for Insurance Affordability Program or for one or more exemptions. All matching is now conducted using single, front-end verification queries, so the Agreement is now titled as an MOU.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-2303-dhs-data-exch.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement (now titled as an MOU).** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.**  All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2304

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the Department of Veterans Affairs (VA) as the source agency.

**Title:** “Verification of Eligibility for Minimum Essential Coverage under the Patient Protection and Affordable Care Act through a Veterans Health Administration Plan”

**Description:** In this matching program, VHA provides CMS with match results from VHA’s 54VA10NB3 system of records to assist CMS and state-based administering entities (AE) in determining whether individuals who apply for financial assistance (i.e., insurance affordability programs, including advance payments of the premium tax credit and cost-sharing reductions) in paying for private health insurance coverage are eligible for a VHA health plan. VHA health plans provide minimum essential coverage; eligibility for such plans precludes eligibility for financial assistance to pay for private coverage. The VHA provides the match results to CMS for any applicant identified in a request submitted by an AE whose identifying data (provided from CMS’s HIX system of records) matches VHA records, but only to the extent that VHA is authorized to release information about that individual.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-va-cma-2304.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2306

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the U.S. Office of Personnel (OPM) as the source agency.

**Title:** “Verification of Eligibility for Minimum Essential Coverage under the Patient Protection and Affordable Care Act through an Office of Personnel Management Health Benefit Plan”

**Description:** In this matching program, OPM provides CMS with monthly data files showing the dates when each active federal employee was eligible for coverage under an OPM health benefit plan, and an annual file indicating the lowest premium available to federal employees in 32 localities. CMS does not share data with OPM to receive this data. CMS and state Administering Entities (AEs) conduct matches against the OPM data to determine if an applicant or enrollee in private coverage under a Qualified Health Plan through the federally-facilitated exchange or a state-based exchange is eligible for an OPM health benefit plan, and therefore not eligible for financial assistance in paying for the private coverage. (Financial assistance includes advance payment of the premium tax credit or a cost sharing reduction.) OPM plans provide minimum essential coverage (MEC); to be eligible for financial assistance in paying for private coverage, an individual must not be eligible for another plan that provides MEC.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-opm-cma-2306.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2307

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the source agency and the Federal Communications Commission (FCC) as the recipient agency.

**Title:** "Disclosure of Information to Support Eligibility Determination for Participation in the Federal Lifeline Program"

**Description:** This matching program provides FCC with information from CMS’ T-MSIS system of records confirming whether applicants and subscribers identified in files submitted by FCC to CMS are eligible for Medicaid. FCC uses the match results as one indicator to determine if the individuals meet low-income eligibility requirements for the Lifeline program; the Emergency Broadband Benefit Program (EBBP) funded under the CARES Act (now known as the Affordable Connectivity Program (ACP)); any extension of or successor to EBBP (now ACP); the National Telecommunications and Information Administration’s Connecting Minority Communities Pilot Program; and any program in any COVID-19 related relief legislation that uses qualification for Lifeline as an eligibility criterion.

**Link posted in the Agency’s website:** [https://www.fcc.gov/sites/default/files/CMS%20VA%20CMA%20#2304%20-%20508-compliant%20Agreement%20to%20post.pdf](https://www.fcc.gov/sites/default/files/CMS%20VA%20CMA#2304%20-%20508-compliant%20Agreement%20to%20post.pdf)

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, based on the last cost benefit analysis prepared, described below.

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** FCC performed a cost-benefit analysis demonstrating that the matching program is likely to be cost effective. The analysis estimates the cost to conduct the matching program for the initial 18-month term of the agreement to be $972,180 (mostly for CMS costs reimbursed by FCC) and demonstrates that the matching program avoided $70.8 million improper payments in FY 2019 (i.e., it attributes 60% of the $118 million fewer improper payments in FY 2019 to the matching program). In addition, it estimates that using matching instead of a manual process saves FCC $13.6 million in costs.

### CMA HHS #2308

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the Peace Corps as the source agency.

**Title:** "Verification of Eligibility for Minimum Essential Coverage under the Patient Protection and Affordable Care Act through a Peace Corps Health Benefit Plan"

**Description:** In this matching program, the Peace Corps provides CMS with updated bulk data files each day, Tuesdays through Saturdays, showing the dates when each Peace Corps volunteer was eligible for coverage under a Peace Corps health benefit plan. CMS does not share data with the Peace Corps to receive this data. CMS and State Administering Entities (AEs) conduct matches against the data to determine whether a Peace Corps volunteer or other relevant individual (e.g., household member) who applies for or is enrolled in private insurance coverage under a Qualified Health Plan through the federally-facilitated exchange or a state-based exchange is eligible for financial assistance in paying for the private coverage. (Financial assistance includes advance payment of the premium tax credit or a cost sharing reduction.) Peace Corps health benefit plans provide minimum essential coverage (MEC); for an individual to be eligible for financial assistance in paying for private coverage, the individual (among other factors) must not be eligible for another plan that provides MEC.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-cma-2308.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2309

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the source agency and the Social Security Administration (SSA) as the recipient agency.

**Title:** "Disclosure of Nursing Care Facility Admission and Discharge Information"

**Description:** This matching program provides SSA with certain nursing care facility information from CMS’s Long-Term Care - Minimum Data Set system of records (LTC/MDS) affecting Supplemental Security Income (SSI) and Special Veterans Benefit (SVB) beneficiaries’ eligibility for benefits and amount of benefits under SSA’s SSI and SVB programs. On a monthly basis, SSA provides CMS with a finder file containing beneficiaries’ names, Social Security Numbers, and other data from SSA’s SSI and SVB system of records; and CMS provides SSA with a response file containing certain nursing care facility admission and discharge data for the beneficiaries identified in the finder file. The match results help SSA to identify, more quickly and cost-effectively than under a manual process, beneficiaries who failed to report admissions to skilled nursing facilities (which affects the amount of their SSI benefit) and SVB beneficiaries who failed to report residency in the United States (which disqualifies them for SVB). SSA uses the data to enforce eligibility requirements and reduce and recover SSI and SVB overpayments.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-cma-2310.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, based on the last cost benefit analysis prepared, described below.

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by SSA; it results in a favorable benefit-to-cost ratio of 6.063 to 1, demonstrating that the matching program is likely to be cost-effective.

### CMA HHS #2310

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the Department of Defense (DoD) as the source agency.

**Title:** "Verification of Eligibility for Minimum Essential Coverage under the Patient Protection and Affordable Care Act through a Department of Defense Health Benefit Plan"

**Description:** The purpose of this matching program is to is to enable DoD to make data from its DEERS system of records available to CMS, for CMS and state Administering Entities (AEs) to use to verify whether individual applicants and enrollees who are applying for financial assistance to pay for private health insurance coverage are eligible for coverage under DoD’s TRICARE Health Care Program. TRICARE provides minimum essential coverage (MEC), and eligibility for such a plan generally precludes eligibility for financial assistance in paying for private coverage. CMS provides DoD with identifying data, submitted by AEs, about applicants and enrollees from CMS’ HIX system of records in order to receive match results from DoD.

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-cma-2310.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. Certain Marketplace query or matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.
2. The Marketplace query and matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The query and matching programs benefit the public and consumers by accurately determining consumers’ eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace query and matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, and improving overall health care delivery.
5. Continuing to use the current query and matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2311

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS), as the source agency and the Defense of Defense (DoD), as the recipient agency.

**Title:** "Disclosure of Enrollment and Eligibility Information for Military Health System Beneficiaries who are Medicare Eligible"

**Description:** This matching program identifies Military Health System (MHS) TRICARE beneficiaries who become eligible for Medicare Part A (due to age or disability) so that DoD can comply with a statutory mandate to discontinue MHS benefits to such beneficiaries unless they enroll in Medicare Part B. Enrolling dual-eligible beneficiaries in Medicare Part B makes Part B the primary payer and TRICARE the secondary payer for claims. Under the matching program, DoD provides weekly finder files to CMS containing Social Security Numbers and other identifying data about all MHS beneficiaries from DoD’s Defense Enrollment Eligibility Reporting System (DEERS) system of records, and CMS provides DoD with each beneficiary’s Medicare Part B enrollment status and address from CMS’ Enrollment Data Base (EDB) system of records. DoD uses the match results to notify relevant MHS beneficiaries that, to maintain TRICARE eligibility, they must be enrolled in Medicare Part B (or provide documentation showing they aren’t entitled to Medicare); discontinue MHS benefits to dual-eligible individuals who don’t enroll in Part B; and correct erroneous information.

**Link posted in the Agency’s website:** <https://dpcld.defense.gov/Portals/49/Documents/Privacy/CMAs/CMA12_2024_Establish.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, based on the last cost benefit analysis prepared, described below.

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by DoD. It doesn’t demonstrate that the matching program is likely to be cost effective, because it doesn’t quantify improper payments avoided or recovered to offset the $177,000 in costs which are estimated to be incurred to conduct the matching program for the initial 18-month term of the agreement. However, the analysis indicates that such costs are approximately $30.9 million less than the $41.2 million it would cost to compare data manually.

### CMA HHS #2314

**Participant Agencies:** HHS’s Centers for Medicare & Medicaid Services (CMS) as the recipient agency and the State Based Administering Entities (AE) as the source agency.

**Title:** "Determining Eligibility for Enrollment in Applicable State Health Subsidy Programs under the Patient Protection and Affordable Care Act"

**Description:** In this matching program, CMS provides to each AE, through the Data Services Hub (Hub), data from CMS’s HIX system of records, which CMS obtains from source federal agencies under other Marketplace-related matching programs for the AE to use in determining individuals’ eligibility for state health subsidy programs. CMS provides such data to an AE in response to identifying information the AE submits to CMS through the Hub about applicants, enrollees, and other relevant individuals. To avoid dual enrollments, each AE shares data under this agreement with CMS and other AEs, verifying whether the individuals are enrolled in or eligible for Medicaid or the Children’s Health Insurance Program (CHIP).

**Link posted in the Agency’s website:** <https://www.hhs.gov/sites/default/files/cms-cma-2314.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, as non-discretionary under the PPACA (i.e., as necessary in order to provide a single, streamlined application process that will maximizes enrollments in Qualified Health Plans under the PPACA).

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by CMS which covers all eight PPACA Marketplace matching programs; it estimates that the total cost for agencies to conduct the eight Marketplace matching programs exceeds $58.9 per year. The analysis explains that the matching programs do not avoid or recover improper payments with which to offset the cost to conduct them but are justified for the following reasons:

1. The Marketplace matching programs have resulted in efficient and accurate consumer eligibility determinations and MEC checks, and substantially reduce the administrative burden on CMS and AEs.
2. The matching programs provide a significant benefit to the public by allowing CMS and AEs to determine consumer eligibility quickly and accurately for QHPS and IAPs while minimizing consumer burden.
3. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace QHPs, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.
4. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

### CMA HHS #2315

**Participant Agencies:** HHS’s Administration for Children and Families (ACF) as the source agency and the Department of Housing and Urban Development (HUD) as the recipient agency.

**Title:** "Verification of Employment and Income and Analysis"

**Description:** This matching program is statutorily required under 42 U.S.C. § 653(j)(7), provided that it does not interfere with efficient operation of child support programs. In the matching program, HHS provides HUD with new hire, quarterly wage, and unemployment insurance information from OCSE’s National Directory of New Hires (NDNH) database, to enable HUD to verify the employment and income of individuals participating in certain rental assistance programs whose names and SSNs are provided to HHS by HUD. HUD also uses the data (with personal identifiers removed) to conduct analyses (i.e., quality control studies) of the participants’ employment and income reporting. Use of the NDNH data for those purposes helps HUD to detect and reduce overpayments of rental housing assistance resulting from tenants’ under-reporting of their income; miscalculation of subsidy amounts; and billing errors by housing providers/administrators.

**Link posted in the Agency’s website:** <https://www.hud.gov/sites/dfiles/OA/documents/HUD-HHS-Agreement.pdf>

**Please provide an account of whether the agency has fully adhered to the terms of the matching agreement.** Yes.

**Please provide an account of whether all disclosures of agency records for use in the matching program continue to be justified.** All disclosures continue to be justified, based on the last cost benefit analysis prepared, described below.

**Please indicate whether a cost-benefit analysis was performed, the results of the cost-benefit analysis, and an explanation of why the agency proceeded with any matching program for which the results of the cost-benefit analysis did not demonstrate that the program is likely to be cost effective.** A cost benefit analysis was prepared by HUD, which demonstrates that the matching program is likely to be cost-effective. It reflects that HUD’s costs to conduct the matching program will total approximately $5.7 over the 2.5 year period of the new Agreement, but that in FY 2023 alone approximately $185 million in overpayments were avoided (i.e., matching detected over $2.3 billion in underreported income by rental recipients which could have resulted in $185 million in overpayments to rental recipients if not for the matching program), resulting in a benefit-to-cost ratio of 32:1.

## **Programs Where Cost/Benefit Analysis was waived**

N/A

## **Matching Agreements the DIB Disapproved**

N/A

## **Any Violations of Matching Agreements that Have Been Alleged or Identified**

N/A