COMPUTER MATCHING AGREEMENT
BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
FOR THE
VERIFICATION OF HOUSEHOLD INCOME AND FAMILY SIZE FOR INSURANCE AFFORDABILITY PROGRAMS AND EXEMPTIONS

Centers for Medicare & Medicaid Services (CMS)
Computer Matching Agreement No. 2024-08

Health and Human Services (HHS)
Computer Matching Agreement No. 2404

Effective Date: April 5, 2025
Expiration Date: October 4, 2026

I. PURPOSE, LEGAL AUTHORITIES, AND DEFINITIONS

A. Purpose

The purpose of this Computer Matching Agreement (Agreement) is to establish the terms, conditions, safeguards, and procedures by which return information, hereafter referred to as federal tax information (FTI), will be provided by the Department of the Treasury (Treasury) Internal Revenue Service (IRS) to the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), for use by CMS and Administering Entities (AEs) in verifying Household Income and Family Size for an Applicant receiving an Eligibility Determination. AEs include the Federally-facilitated Exchange (FFE), State-based Exchanges (SBEs), state Basic Health Programs (BHPs), and approved State Medicaid or Children's Health Insurance Program (CHIP) agencies.

FTI will be matched by AEs for the purpose of determining initial eligibility for enrollment and making eligibility redetermination and renewal decisions for the following benefits: (1) advance payments of the premium tax credit (APTC) under §§ 1401, 1411 and 1412 of the Patient Protection and Affordable Care Act (ACA) (Public Law No. 111-148); (2) a cost-sharing reduction (CSR) under § 1402 of the ACA; (3) Medicaid and the CHIP, under Titles XIX and XXI of the Social Security Act (the Act), pursuant to § 1413 of the ACA (42 U.S.C. § 18083); or (4) a State's BHP, if applicable, under § 1331 of the ACA. FTI may also be used for determining eligibility for certain certificates of exemption.

The Privacy Act of 1974, as amended (5 United States Code (U.S.C.) § 552a) (Privacy Act), 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 verifications conducted by the Federal Data Services Hub (Hub) and AEs accessing IRS data constitutes a "matching program" as defined in the Privacy Act.

The terms and conditions of this Agreement will be carried out by authorized employees and contractors of CMS and IRS. (CMS and IRS are each a Party, and collectively the Parties). The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the recipient agency. The IRS component responsible for the disclosure of information is the Submission Processing, Customer Account Services, Wage and Investment Division. The IRS will serve as the source agency.

IRS acknowledges that AEs will use IRS data accessed through the Hub to make Eligibility Determinations. The Parties acknowledge that CMS will enter into separate matching agreements and information exchange agreements, consistent with the terms and conditions set forth in this Agreement with AEs other than the FFE, through which AEs will access IRS data through the Hub to conduct determinations of eligibility.

B. Legal Authorities

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

1. This Agreement is executed pursuant to the Privacy Act and the regulations and guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 "Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act" published at 81 Federal Register (FR) 94424 (December 23, 2016), and OMB guidelines pertaining to computer matching published at 54 FR 25818 (June 19, 1989). The Privacy Act at 5 U.S.C. § 552a(b)(3) authorizes a federal agency to disclose information about an individual that is maintained in a system of records, without the individual's prior written consent, when the disclosure is pursuant to a routine use published in a System of Records Notice (SORN) as required by 5 U.S.C. § 552a(e)(4)(D). The Parties have published routine uses for their applicable systems of records which authorize the disclosures made under this Agreement.

2. Under the ACA, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a Qualified Health Plan (QHP) when enrollment is through an Exchange. This assistance includes APTC, under 26 U.S.C. § 36B and § 1412 of the ACA, and CSRs under § 1402 of the ACA.

3. Section 1414 of the ACA amended 26 U.S.C. § 6103 to add paragraph (l)(21), which authorizes the disclosure of certain items of FTI as part of the eligibility requirements for certain programs, including: any APTC under Section 36B of the Internal Revenue Code (IRC); CSR under Section 1402 of the ACA; Medicaid and CHIP, under titles XIX and XXI of the Social Security Act; or a BHP, under Section 1331 of the ACA.

4. Section 1413 of the ACA (42 U.S.C. § 18083) establishes a system under which individuals may apply for enrollment in and receive an eligibility determination for participation in an Insurance Affordability Program. The program established by the Secretary of HHS under § 1413 of the ACA provides for the Secretary of HHS to transmit information through a secure interface to the Secretary of the Treasury from individuals applying for participation using a single streamlined form. Under the authority of Section 1413(a) and based on the authorized uses and disclosures of FTI, the Secretary of HHS adopted regulations (42 CFR §§ 435.940, 435.945, 435.948, 435.949, 435.952, 435.956 and 45 CFR part 155 subpart D), which address the procedure for verification of Household Income and Family Size based on coordination between CMS and IRS.

5. Sections 1411(c)(3), (c)(4) and (e) of the ACA require that IRS must electronically disclose FTI to CMS to support the verification of Household Income and Family Size for an applicant seeking an eligibility determination for APTC and CSR.

6. Section 1411(f)(1) of the ACA also requires the Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security to establish procedures for re-determining eligibility for enrollment in a QHP through an Exchange, APTC and CSR on a periodic basis. Periodic renewal of eligibility for Medicaid and CHIP are required by 42 CFR §§ 435.916, 457.343 and 457.960. Periodic review and renewal of BHP eligibility is required by 42 CFR § 600.340.

7. Under the authority of §§ 1311, 1321, and 1411(a) of the ACA, the Secretary of HHS adopted regulations, 45 CFR §§ 155.330 and 155.335, which further address the requirements for an Exchange to re-determine eligibility for enrollment in a QHP through an Exchange and for APTC and CSRs during the Benefit Year based on certain types of changes in circumstances as well as on an annual basis.

8. Sections 1311(d)(4)(H) and 1411(a)(4) of the ACA specify that the Exchange will determine eligibility for, and issue certificates of Exemption.

9. Section 1943(b) of the Act (as added by § 2201 of the ACA) requires Medicaid and CHIP agencies to use the same streamlined enrollment system and secure electronic interface established under § 1413 of the ACA (42 U.S.C. § 18083) to verify information, including Household Income and Family Size, needed to make an eligibility determination and facilitate a streamlined eligibility and enrollment system among all Insurance Affordability Programs. 42 CFR § 600.310(a) requires BHP to use the same single streamlined application as Medicaid and the Exchange.

10. Section 1411(f)(1) of the ACA also requires the Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security to establish procedures for hearing and deciding appeals of eligibility determinations for enrollment in a QHP through an Exchange, APTCs and CSRs, and Exemptions. Appeals of denials of Medicaid and CHIP

eligibility are required by, respectively, § 1902(a)(3) of the Act and 42 CFR part 431, subpart E and 42 CFR part 457, subpart K. Appeals of BHP eligibility are required by 42 CFR § 600.335.

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), codified at 42 U.S.C. 18001, et seq. (collectively, the ACA);

2. "Administering Entity" means a state Medicaid agency, state Children's Health Insurance Program (CHIP), a state Basic Health Program (BHP), or an Exchange (either Federally-facilitated or State-Based) administering an Insurance Affordability Program;

3. "Applicant" means an individual who is seeking an Eligibility Determination for Insurance Affordability Programs or for an Exemption through an application;

4. "APTC" means advance payment of the premium tax credit specified in § 36B of the IRC (as added by § 1401 of the ACA) which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Sections 1401, 1411 and 1412 of the ACA;

5. "Basic Health Program" or "BHP" means an optional state program established under Section 1331 of the ACA or under a Section 1332 waiver program;

6. "Benefit Year" means the calendar year of coverage provided by a QHP offered through an Exchange;

7. "Breach" is defined by OMB Memorandum M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information, January 3, 2017, as the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where (a) a person other than an Authorized User accesses or potentially accesses personally identifiable information (PII); or (b) an Authorized User accesses or potentially accesses PII for an other-than-authorized purpose;

8. "Children's Health Insurance Program" or "CHIP" means the state program established under Title XXI of the Act;

9. "Cost-sharing reductions" or "CSR" means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual member or shareholder of a federally recognized Indian tribe or Alaska Native Claims Settlement Act Corporation enrolled in a QHP offered in an Exchange;

10. "Enrollee" means a qualified individual or qualified employee enrolled in a QHP under Title I of the ACA for the enrollment in QHP offered through an Exchange, or an

individual enrolled in a state BHP;

11. "Exchange"(otherwise known as Marketplace) means a Federally-facilitated Exchange (FFE) or a State-based Exchange (SBE) (including a not-for-profit exchange) established under section 1311(b), 1311(d)(1) or 1321(c)(1) of PPACA. For purposes of this Agreement, all references to an Exchange shall refer equally to and include a state agency that is responsible for administering the Insurance Affordability Program under which individuals and small businesses may enroll in Qualified Health Plans in the state;

12. "Exemption" means an exemption from the individual shared responsibility provisions under 26 U.S.C. § 5000A;

13. "Family Size" is defined under 26 U.S.C. § 36B(d)(1) and 42 CFR § 435.603(b);

14. "Federally-facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under § 1321(c)(1) of the ACA;

15. "Household Income" is defined under 26 U.S.C. § 36B(d)(2)(A) in determining eligibility for APTC and CSR and 42 CFR § 435.603(e) for purposes of MAGI conversion within Medicaid;

16. "Hub" or the Federal Data Services Hub is the CMS managed service to interface among connecting entities;

17. "Insurance Affordability Programs" means a program that is one of the following: (1) a State Medicaid program under Title XIX of the Act; (2) a State CHIP under Title XXI of such Act; (3) a state BHP established under § 1331 of the ACA; (4) a program that makes coverage in a QHP through the Exchange with APTC; or (5) a program that makes available coverage in a QHP through the Exchange with CSR;

18. "Modified Adjusted Gross Income" or "MAGI" is defined under 26 U.S.C. § 36B(d)(2)(B);

19. "Medicaid" means the state program established under Title XIX of the Act;

20. "Medicaid/CHIP Beneficiary" means an individual who has been determined eligible and is currently receiving Medicaid or CHIP benefits;

21. "NIST" means the National Institute of Standards and Technology;

22. "Personally Identifiable Information" or "PII" is defined by OMB M-17-12 (January 3, 2017), and means information that can be used to distinguish or trace an individual's identity, either alone or in combination with other information that is linked or linkable to a specific individual;

23. “Qualified Health Plan” or “QHP” is defined in 45 CFR § 155.20 and means a health plan for which a certification has been issued or recognized by each Exchange through which the plan is offered (pursuant to the certificate process described in 45 CFR Part 155, subpart K) demonstrating that the plan meets the minimum standards described in 45 CFR Part 156, subpart C;

24. “Redetermination” means the process by which an Exchange determines eligibility for APTC or CSR, and/or an Exemption after the initial Eligibility Determination in one of two circumstances: (1) on an annual basis prior to open enrollment; and/or (2) a change in circumstances occurs, such as when an individual communicates an update to an Exchange that indicates a change to the individual’s Household Income or Family Size, or when the Exchange discovers a change in circumstances under 45 CFR § 155.330;

25. “Reference Tax Year” means the first calendar year or, if no FTI is available for that year, the second calendar year, prior to the Benefit Year;

26. “Relevant Taxpayer” means any individual listed, by name and SSN (“taxpayer identity information”), on the application for an Insurance Affordability Program or for an Exemption whose income may affect the Eligibility Determination of an individual for an Insurance Affordability Program or an Exemption;

27. “Renewal” means the annual process for a Medicaid/CHIP beneficiary to be considered for continued coverage under a state Medicaid program or CHIP, or the annual process for a BHP enrollee to be considered for continued coverage under a state BHP;

28. “Return information” is defined under 26 U.S.C. § 6103(b)(2) and has the same meaning as federal tax information (FTI) as used in IRS Publication 1075, “Tax Information Security Guidelines for Federal, State and Local Agencies”;

29. “Security Incident” or “Incident” is defined in OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017) as an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies;

30. “System of Records” or “SOR” as defined by the Privacy Act at 5 U.S.C. § 552a(a)(5), means a group of any records about an individual under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual;

31. “System of Records Notice” or “SORN” means a notice published in the Federal Register, providing notice of the existence and character of a system of records maintained by a federal agency, as required by the Privacy Act at 5 U.S.C. § 552a(e)(4);

32. "Safeguard Security Report" or "SSR" means the report required by 26 U.S.C. § 6103(p)(4)(E) which is filed in accordance with IRS Publication 1075 to detail the safeguards established to maintain the confidentiality of FTI received from the Hub or in an account transfer;

33. "Treasury Inspector General for Tax Administration" or "TIGTA" is the office established under 31 U.S.C. § 402 which provides independent oversight of IRS activities and the federal tax system.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities

1. Submission of Data (from an AE): Prior to submitting a request to IRS, CMS must validate the SSN of each Applicant, Medicaid/CHIP Beneficiary, Enrollee, or Relevant Taxpayer with the Social Security Administration (SSA) or through documentation of SSN provided by the Applicant, Medicaid/CHIP Beneficiary, Enrollee, or Relevant Taxpayer. Un-validated SSNs will not be included in the request to IRS.

2. To submit a request for Household Income and Family Size to the IRS through the Hub, an AE must include the Relevant Taxpayer's name, SSN, and the taxpayer relationship (primary, spouse, or dependent) to any Applicant, Enrollee, or Medicaid/CHIP Beneficiaries listed on an application.

3. As part of the initial application for Insurance Affordability Programs, where FTI is disclosed in accordance with Treas. Reg. section 301.6103(l)(21)-1, the AE will give Applicants, Enrollees and/or Medicaid/CHIP beneficiaries the option to authorize the AE to make future eligibility determinations based on the initial application as part of the annual Redetermination and Renewal processes, for a period not to exceed 5 years based on a single application, in accordance with 45 CFR 155.335(k). The Redetermination and Renewal process includes obtaining updated FTI of relevant taxpayers from IRS pursuant to 31 U.S.C. § 6103(l)(21) to compare with the information provided on the application. Such an option will be provided on the single-streamlined application for Eligibility Determinations. Applicants, Enrollees and Medicaid/CHIP Beneficiaries may also discontinue, change, or renew their authorization. Current Medicaid/CHIP Beneficiaries renewing coverage will be provided the option to authorize the AE to make future eligibility determinations based on their initial application as part of the renewal Eligibility Determination. CMS will ensure AEs maintain records that properly account for the option elected by each Applicant, Enrollee or Medicaid/CHIP Beneficiary, and will not obtain updated FTI for use in annual Redeterminations for years in which the Applicant, Enrollee or Medicaid/CHIP Beneficiary did not authorize.

4. For each Enrollee or Medicaid/CHIP Beneficiary, at the time of the beneficiary's annual or periodic eligibility Redetermination or Renewal, the Relevant Taxpayer's name, SSN, and the taxpayer relationship to any Applicants, Enrollees, or

Medicaid/CHIP Beneficiaries on the application (primary, spouse, or dependent) must be submitted to IRS through the Hub.

5. Each AE must be uniquely identified when requesting FTI so that authorization to receive FTI is validated by IRS prior to disclosure to CMS. AEs are authorized to receive FTI via the Hub pursuant to this matching Agreement and through a separately executed Computer Matching Agreement with CMS.

6. For each individual who submits an application for certain Exemptions under § 1311(d)(4)(H) of the ACA to an AE and for whom the AE seeks to use FTI for verification, the Relevant Taxpayer's name, SSN, and the taxpayer relationship to any other individuals seeking an Exemption (primary, spouse, or dependent) must be submitted to IRS through the Hub.

7. CMS must not disclose any FTI to any AE that is not approved to receive FTI as evidenced by a letter of acceptance from the IRS of an approved SSR and maintained on the authorized list provided by the IRS.

8. When both the HHS Data Integrity Board (DIB) and the Treasury DIB approve this agreement, CMS will submit a report of the Matching Program to Congress and OMB for their advance review and will provide a copy of such notification to IRS. Upon completion of OMB's advance review, CMS will publish the Federal Register notice required by 5 U.S.C. § 552a(e)(12).

9. CMS will require, by means of a written agreement, that each AE will:

    a. Retain FTI no longer than necessary to conduct the AE's functions related to Eligibility Determinations or Exemption determinations, appeals, and submission of notices or no longer than is otherwise required by applicable law. Each AE will comply with 26 U.S.C. § 6103(p)(4) and IRS Publication 1075 with respect to all retained FTI; and

    b. Comply with Section IX of this Agreement.

B. CMS Hub Responsibilities

1. The Hub will coordinate the transmission of requests and responses between the AEs and IRS. A request for verification of Household Income or Family Size may be initiated by an AE sending a request to the Hub.

2. The Hub will transmit to IRS the full name, SSN, and taxpayer relationship (primary, spouse, or dependent), for each Relevant Taxpayer in the Applicant's tax or Medicaid household.

3. The Hub will not permanently maintain/retain any FTI. Some temporary retention of the data at the Hub will be necessary. The Hub will comply with 26 U.S.C. §

6103(p)(4) and IRS Publication 1075 with respect to all temporarily maintained/retained FTI.

4. The Hub will erase the matching file generated through this matching operation as soon as the information has served the matching program's purpose and all legal retention requirements established in conjunction with the National Archives and Records Administration under applicable procedures have been met.

5. Household Income and Family Size verification for a new application for Insurance Affordability Programs and self-reported changes in income during the Benefit Year will be performed in accordance with separately executed service level agreements between CMS and IRS.

6. Household Income and Family Size verifications for annual Redeterminations for Insurance Affordability Programs will generally occur between August and October in accordance with separately executed service level agreements between CMS and IRS. Annual Renewals for individuals enrolled in Medicaid or CHIP will occur throughout the year in accordance with separately executed service level agreements between CMS and IRS. At the election of the AE administering a BHP, annual renewals for individuals enrolled in a BHP will generally occur between August and October or throughout the year in accordance with separately executed service level agreements between CMS and IRS.

7. Household Income and Family Size verifications performed for the purposes of determining eligibility for Medicaid, CHIP, or BHP will be performed throughout the year in accordance with separately executed service level agreements between CMS and IRS.

8. Household Income and Family Size verifications performed for the purposes of determining eligibility for Exemptions will be performed throughout the year in accordance with separately executed service level agreements between CMS and IRS.

9. CMS and IRS will exchange information via the Hub, and in near real-time during normal service hours in accordance with separately executed service level agreements between CMS and IRS.

10. CMS will transmit the records through the Hub to IRS electronically and encrypted using Transport Layer Security (TLS) communication protocol with mutual authentication.

C. IRS Responsibilities

1. Upon receipt of a request from the Hub, in accordance with 26 U.S.C. § 6103(l)(21) and its implementing regulations, IRS will extract FTI as described in Section IV.C, below. See Section II.B.5-II.B.8 for details regarding the timing of this process for

Applicants, Enrollees or Medicaid/CHIP Beneficiaries.

2. IRS will transmit the extracted records to CMS, via the Hub, electronically and encrypted using TLS communication protocol with mutual authentication.

3. IRS will maintain a list of AEs which have established the safeguards required by 26 U.S.C. § 6103(p)(4) as a condition for receipt of FTI from CMS. IRS Safeguards, Office of Governmental Liaison, Disclosure and Safeguards (GLDS), hereafter referred to as IRS Safeguards, will provide the list of authorized entities to CMS and notify CMS of any additions or deletions from the list.

4. CMS and IRS will exchange information via the Hub and in real-time during normal service hours in accordance with separately executed service level agreements between CMS and IRS.

III. JUSTIFICATION AND ANTICIPATED RESULTS

A. Cost-Benefit Analysis

As required by § 552a(u)(4) of the Privacy Act, a cost-benefit analysis (CBA) is included as Attachment 1, covering this and seven other matching programs which CMS conducts with other Federal agencies for the purpose of implementing Insurance Affordability Programs. The CBA demonstrates that monetary costs to operate the eight matching programs include approximately $2.2 million per year for internal CMS costs, $19.8 million per year paid by CMS to TDS agencies, and an undetermined portion of $50 million per year for Hub operations, but the CBA does not quantify direct governmental cost-saving benefits that offset the costs. The CBA, therefore, does not demonstrate that the matching program is likely to be cost-effective and does not provide a favorable benefit/cost ratio.

However, other supporting justifications and mitigating factors which support approval of this Agreement are provided below in Section B. Further, OMB guidance at 54 FR 25818 and 25828 (June 19, 1989) provides that when a matching program is being negotiated for re-establishment, the Privacy Act "does not require the showing of a favorable ratio for the match to be continued, only that an analysis be done. The intention is to provide Congress with information to help it evaluate the effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate."

B. Other Supporting Justifications

Although the CBA does not demonstrate that this matching program is likely to be cost-effective, the program is justified for other reasons, as explained in this section. In accordance with 5 U.S.C. § 552a(u)(4)(B), the DIB may waive the requirements of a CBA if it determines in writing, in accordance with guidelines prescribed by the Director of the OMB, that a CBA is not required.

1. This matching program is arguably required, not discretionary. The ACA did not expressly mandate the use of computer matching, but effectively required it by requiring a single, streamlined application process for consumers.

2. The matching programs' verification service results in improved accuracy of consumer Eligibility Determinations, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieving operational efficiencies.

3. The matching programs provide a significant net benefit to the public by accurately determining eligibility for insurance affordability programs.

4. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in QHP coverage on the exchanges, resulting in a reduction of the uninsured population, thereby improving overall health care delivery.

5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

C. Specific Estimate of Any Savings

Because the goal of the matching programs is to maximize enrollments in qualified health plans to reduce the uninsured population, not to avoid or recover improper payments, the CBA does not result in favorable benefit/cost ratio. The CBA examines how efficiently the matching programs are structured to limit costs and concludes that the existing structure remains more efficient (less costly) than any alternatives.

IV. RECORDS DESCRIPTION

A. Systems of Records (SOR)

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

2. The IRS SOR that supports this matching program is FTI Treasury/IRS 24.030, published at 80 FR 54064 (September 8, 2015). This routine use requires that disclosure of returns and FTI may be made only as provided by 26 U.S.C. § 6103.

B. Number of Records Involved

The total number of Household Income and Family Size transactions in FY 2023 was 44,474,126, with the highest month (November) having 7,634,041 transactions. The estimated transaction volume for FY 2024 is 61,686,352, with the highest month estimated to see 10,129,410 transactions. These estimates use current business assumptions, and do

not de-duplicate records if applicants submit multiple application updates. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

C. Specific Data Elements Used in the Match

When IRS is able to match a SSN and name provided from the Hub and FTI is available, IRS will disclose to CMS, through the Hub, the following items of FTI with respect to each Relevant Taxpayer:

1. SSN;
2. Family size;
3. Filing status;
4. MAGI;
5. Taxable Social Security benefits
6. AGI for adjusted tax returns
7. Taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available; and
8. Any other specified item of FTI authorized pursuant to 26 U.S.C. § 6103(l)(21) and its Implementing regulations.

When Household Income and Family Size is unavailable, IRS generates a response code and discloses to CMS through the Hub the following FTI with respect to each Relevant Taxpayer:

1. Unable to provide data due to authentication issue;
2. Unable to provide income data due to spouse mismatch;
3. FTI is unavailable;
4. Tax household did not file a tax return and reconcile APTC;
5. No dependent filing requirement;
6. Tax household has a valid filing extension and has not reconciled APTC; or
7. Tax household filed a tax return and did not reconcile APTC.

D. Frequency of Data Exchanges

The data exchanges under this agreement will begin April 5, 2025, and continue through October 4, 2026, in accordance with schedules set by CMS and IRS. CMS will submit requests electronically in real-time processing on a daily basis throughout each year.

V. NOTICE PROCEDURES

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

At the time of application or change of circumstances, an AE will, on behalf of CMS, provide a notice to Applicants for enrollment in a QHP or an Insurance Affordability Program on the streamlined eligibility application. The AE will ensure provision of a Redetermination or

Renewal notice in accordance with applicable law. These notices will inform Applicants that the information they provide may be verified with information in the records of other Federal agencies.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

The Privacy Act 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. Advance Payment of the Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR)

1. The Exchange may verify FTI provided by the IRS with certain information provided by an Applicant on the application and information used for Redeterminations for an Enrollee with FTI provided by the IRS to determine reasonable compatibility in accordance with 45 CFR §§ 155.320, 155.330(e), and 155.335(f). Pursuant to the verification process in 45 CFR §§ 155.320(c), 155.315(f), 155.330(e) and 155.335(f), the Exchange will provide notice to and an opportunity to resolve the inconsistency for the Applicant or Enrollee if there is an inconsistency between the Applicant/Enrollee's attestation and the FTI obtained from the IRS through the Hub in connection with Eligibility Determinations and Redeterminations for APTC and CSR. See also § 1411(e)(3) and (4) of the ACA (42 U.S.C. § 18081).

2. In addition, the Exchange will provide notice of appeals procedures with a notice of Eligibility Determination and Redetermination pursuant to 45 CFR §§ 155.230 and 155.355. An Applicant or Enrollee will be provided the opportunity to appeal denials of eligibility for APTC and CSR pursuant to § 1411(f)(1) of the ACA (42 U.S.C. § 18081). FTI may be disclosed to an Applicant or Enrollee only upon proper authorization of each Relevant Taxpayer for whom FTI was disclosed.

B. Exemptions

The Exchange may verify certain information provided by an Applicant for an Exemption with FTI provided by the IRS to determine reasonable compatibility in accordance with 45 CFR §§ 155.615(f) and (g) and 155.620(c). Pursuant to the verification process in 45 CFR §§ 155.615(f) and (g) and 155.620(c), the Exchange will provide notice to and an opportunity to resolve the inconsistency for the Applicant if there is an inconsistency between the Applicant's attestation and the FTI obtained from the IRS through the Hub in connection with Eligibility Determinations for Exemptions. See also § 1411(e)(3) and (4) of the ACA (42 U.S.C. § 18081). In addition, the Exchange will provide Applicants with notice of appeals procedures with a notice of Eligibility Determination pursuant to 45 CFR §§ 155.230 and 155.635. An Applicant will be provided the opportunity to appeal denials of eligibility for an Exemption pursuant to § 1411(f)(1) of the ACA (42 U.S.C. § 18081). FTI may be disclosed to an Applicant only upon

proper authorization of each Relevant Taxpayer for whom FTI was disclosed.

C. Medicaid and CHIP

A State Medicaid or CHIP program must determine or renew eligibility based on information provided in accordance with 42 CFR §§ 435.916 and 457.380. An Applicant, or Medicaid/CHIP Beneficiary seeking to contest any information used for verification of an application or Renewal determination that results in an adverse Eligibility Determination may file an appeal with the agency that issued the Eligibility Determination. FTI may be disclosed to an Applicant or Medicaid/CHIP Beneficiary only upon proper authorization of each Relevant Taxpayer for whom FTI was disclosed.

D. Basic Health Plan (BHP)

To determine reasonable compatibility in accordance with 42 CFR § 600.345, the AE administering a BHP may verify FTI provided by the IRS with certain information provided by an Applicant on the application. The AE may also verify information used for Renewals for an Enrollee with FTI provided by the IRS. Pursuant to the verification process in 42 CFR § 600.345, and in connection with Eligibility Determinations and Renewals for BHP, the AE administering a BHP will notify the Applicant or Enrollee if there is an inconsistency between the Applicant/Enrollee's attestation and the FTI obtained from the IRS through the Hub and will provide an opportunity for the Applicant/Enrollee to resolve the inconsistency.

In addition, the AE administering a BHP will provide notice of appeal rights and procedures with a notice of Eligibility Determination and Renewal pursuant to 42 CFR § 600.335. FTI may be disclosed to an Applicant or Enrollee only upon proper authorization of each Relevant Taxpayer for whom FTI was disclosed.

E. Individuals may use tax administration procedures established by the IRS to correct or amend tax records on file with the IRS. Information provided to an AE to resolve and will be used only for an Eligibility Determination, Redetermination or Renewal and will not be used to amend or change the FTI held by the IRS.

VII. DISPOSITION OF MATCHED ITEMS

A. All AEs authorized by CMS and the Hub will:

1. Maintain all FTI received from IRS in accordance with applicable law, including 26 U.S.C. § 6103(p)(4) and IRS Publication 1075, which are available at https://www.irs.gov. The Hub will not permanently maintain FTI;

2. Not create a separate file or SOR consisting of information concerning only those individuals who are involved in this specific matching program, except as is necessary to control or verify the information for purposes of this program; and

3. Erase the matching file generated through this matching operation as soon as the

information has served the matching program's purpose and all legal retention requirements, including those established in conjunction with the National Archives and Records Administration under applicable procedures have been met.

B. The information provided by CMS is not used by the IRS for any purpose other than this matching program. The IRS Office of Records & Information Management has deemed this information to be of a transitory nature, or "transitory records", specifically intermediate input files as defined in General Records Schedule 5.2, Item 010. The IRS will protect transitory records in the same manner that CMS protects IRS records under this agreement.

VIII. SAFEGUARD REQUIREMENTS AND SECURITY PROCEDURES

A. CMS will maintain FTI received from the IRS in accordance with IRC § 6103(p)(4) and comply with the safeguarding requirements set forth in Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies, which is the IRS published guidance for security guidelines and other safeguards for protecting returns and FTI pursuant to 26 CFR 301.6103(p)(4)-1. Specifically, as required by IRS safeguarding requirements:

1. CMS, the Hub, and all AEs to which CMS provides FTI will establish a central point of control for all requests for and receipt of FTI, and maintain a log to account for all subsequent disseminations and products made with/from that information, and movement of the information until destroyed, in accordance with Publication 1075.

2. CMS, the Hub, and all AEs to which CMS provides FTI will establish procedures for secure storage of FTI, consistently maintaining two barriers of protection to prevent unauthorized access to the information, including when in transit, in accordance with Publication 1075.

3. CMS, the Hub, and all AEs to which CMS provides FTI will consistently label FTI obtained under this Agreement to make it clearly identifiable and to restrict access by unauthorized individuals. Any duplication or transcription of FTI creates new records which must also be properly accounted for and safeguarded. FTI should not be commingled with other CMS records unless the entire file is safeguarded in the same manner as required for FTI, and the FTI within is clearly labeled in accordance with Publication 1075.

4. CMS, the Hub, and all AEs to which CMS provides FTI will restrict access to FTI solely to CMS officers, employees, and contractors whose duties require access for the purposes of carrying out this Agreement. Prior to access, CMS must evaluate which employees or contractors require such access. Authorized individuals may only access FTI to the extent necessary to perform services related to this Agreement, in accordance with Publication 1075.

5. Prior to initial access to FTI and annually thereafter, CMS will ensure that its employees, officers, and contractors that will have access to FTI receive awareness training regarding the confidentiality restrictions applicable to the FTI and certify acknowledgement in writing that

they are informed of the criminal penalties and civil liability provided by IRC §§ 7213, 7213A, and 7431 for any willful disclosure or inspection of FTI that is not authorized by the IRC, in accordance with Publication 1075.

6. CMS and each AE will submit an annual Safeguard Security Report (SSR) to the Office of Safeguards by the submission deadline specified in Publication 1075 to provide an update on safeguarding activities during the reporting period and provide Head of Agency certification that the SSR addresses all Outstanding Actions identified by the Office of Safeguards from CMS' and each AE's prior year's SSR; accurately and completely reflects CMS' and each AE's current environment for the receipt, storage, processing and transmission of FTI; accurately reflects the security controls in place to protect the FTI in accordance with Publication 1075 and of the CMS' and each AE's commitment to assist the Office of Safeguards in the joint effort of protecting the confidentiality of FTI; report all data incidents involving FTI to the Office of Safeguards timely; to cooperate with the IRS Office of Safeguards, providing data and access as needed to determine the facts and circumstances of the incident; support the Office of Safeguards on-site review to assess CMS and each AE's compliance with Publication 1075 requirements by means of manual and automated compliance and vulnerability assessment testing, including coordination with information technology (IT) divisions to secure pre-approval, if needed, for automated system scanning and to support timely mitigation of identified risk to FTI in the CMS' and each AE's Corrective Action Plan (CAP) for as long as CMS and each AE maintains FTI. Required reports will be transmitted in electronic format and on the template provided by Office of Safeguards using an IRS-approved encryption method in accordance with Publication 1075.

7. CMS will ensure that FTI is properly destroyed or returned to the IRS when no longer needed based on established CMS record retention schedules in accordance with Publication 1075.

8. CMS will conduct periodic internal inspections of facilities where FTI is maintained to ensure IRS safeguarding requirements are met and will permit the IRS access to such facilities as needed to review the extent to which CMS is complying with the IRC § 6103(p)(4) requirements.

9. IRC § 6103(p)(9) requires CMS to conduct on-site assessments of each contractor's compliance with safeguarding requirements. CMS must submit findings of the most recent review as part of the annual SSR submission. CMS must certify to the IRS that each contractor is in compliance with safeguarding standards in accordance with Publication 1075. CMS must ensure that contracts with contractors and subcontractors performing work involving FTI contain specific language requiring compliance with IRC § 6103(p)(4) and Publication 1075 standards. Contract language must enforce CMS' right to access contractor and subcontractor facilities in order to comply with IRC § 6103(p)(9) to ensure IRS safeguarding requirements are met.

B. Generally, this Agreement covers secure electronic transmission of FTI to CMS and each AE and requires CMS' and each AE's computer systems to be compliant with National Institute of Standards and Technology (NIST) Special Publication 800-53 standards and guidance for security of data at the moderate impact level. CMS' and each AE's SSR must fully describe the computer system and security controls implemented for the receipt, processing, storage, and transmission of FTI. Required security controls for systems that receive, process, store and

transmit electronic FTI are specified in Publication 1075 and the Internal Revenue Code, as amended (26 U.S.C. § 6103);

C. Any creation of FTI in paper format must also be fully disclosed in the CMS' and each AE's SSR. Required security controls associated with the receipt, processing, and storage of any FTI converted to paper format are specified in previously mentioned sections of Publication 1075.

D. CMS and each AE must report suspected unauthorized inspection or disclosure of FTI immediately, but no later than 24 hours after identification of a possible issue involving FTI to the IRS Office of Safeguards in accordance with guidance specified in Publication 1075.

When a data incident results in CMS and each AE taking adverse or disciplinary action against an employee based on an unauthorized inspection or disclosure of FTI in violation of CMS' and each AE's procedures, CMS must notify each impacted taxpayer in writing. The notification letter must include the date of the unauthorized inspection or disclosure and the rights of the taxpayer under IRC § 7431. CMS must report to IRS Safeguards when taxpayer notification letters are issued, in accordance with Publication 1075.

E. IRS will conduct periodic safeguard reviews of CMS to assess whether security and confidentiality of FTI provided under this matching program is maintained consistent with the safeguarding protocols described in Publication 1075, CMS' SSR, and in accordance with the terms of this Agreement. Periodic safeguard reviews will involve the inspection of CMS facilities where FTI is maintained; the testing of technical controls for computer systems storing, processing, or transmitting FTI; review of CMS recordkeeping and policies; and interviews of CMS employees to verify the use of FTI and to assess the adequacy of procedures established to protect FTI.

F. CMS recognizes and treats all Safeguards documents and related communications as IRS official records; that they are property of the IRS; that IRS records are subject to disclosure restrictions under federal law and IRS rules and regulations and may not be released publicly under state Sunshine or Information Sharing/Open Records provisions and that any requestor seeking access to IRS records should be referred to the federal Freedom of Information Act (FOIA) statute. If CMS determines that it is appropriate to share Safeguards documents and related communications with another governmental function/branch for the purposes of operational accountability or to further facilitate protection of FTI that the recipient governmental function/branch must be made aware, in unambiguous terms, that the Safeguards documents and related communications are property of the IRS; that they constitute IRS official records; that any request for the release of IRS records is subject to disclosure restrictions under federal law and IRS rules and regulations; and that any requestor seeking access to IRS records should be referred to the federal FOIA statute. Federal agencies in receipt of FOIA requests for Safeguards documents must forward them to IRS for reply.

IX. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS

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

A. CMS and IRS will use and disclose the data only for the purposes described in this Agreement or required by Federal law.

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

C. The matching data exchanged under this Agreement remain the property of each Party and will be destroyed after match activity involving the data has been completed or after relevant retention periods have expired under applicable law as described under this matching program.

D. CMS and AEs will restrict access to the data matched to authorized officers, employees, contractors who require access to FTI under this Agreement. CMS FFE will disclose FTI only as authorized under 26 U.S.C. § 6103 to applicants, enrollees or Medicaid/CHIP Beneficiaries and their properly authorized representatives to support eligibility determinations.

E. Any individual who knowingly and willfully uses or discloses information obtained pursuant to this Agreement in a manner or for a purpose not authorized by 45 CFR § 155.260 and § 1411(g) of the ACA (42 U.S.C. § 18081) are potentially subject to the civil penalty provisions of § 1411(h)(2) of the ACA (42 U.S.C. § 18081), which carries a fine of not more than $25,000 per person or entity, per use or disclosure.

X. RECORDS ACCURACY ASSESSMENTS

A. CMS will validate all SSNs and names provided by an AE via the Hub against the records at the SSA or through SSN documentation provided by the Applicant before CMS initiates a request to IRS for the verification of Household Income and Family Size.

B. IRS provides FTI from filed returns. The accuracy of such FTI is dependent on the information included on the return.

C. For purposes of Family Size and Income Verification, CMS will label FTI provided by the IRS in the same manner as the IRS labels the original transmission.

XI. COMPTROLLER GENERAL ACCESS

The Government Accountability Office (Comptroller General) may have access to IRS and CMS records, to the extent authorized by 26 U.S.C. § 6103 and 5 U.S.C. § 552a(o)(1)(K), for purposes of monitoring and verifying compliance with this Agreement.

XII. REIMBURSEMENT/FUNDING

CMS will not reimburse IRS for any costs associated with this Agreement. If, at a future date, both Parties agree that CMS will reimburse IRS for any activities described herein, a separate

Interagency Agreement will be executed to address relevant costs.

XIII. DURATION OF AGREEMENT

A. Effective Date: The effective date of this Agreement will be April 5, 2025, provided that CMS reported the proposal to re-establish this matching agreement to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of their advance review period, CMS published notice of the matching program in the Federal Register for at least thirty (30) days in accordance with 5 U.S.C. § 552a(e)(12).

B. Term: The Agreement will be in effect for a period of eighteen (18) months.

C. Renewal: The DIBs of HHS and Treasury may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for not more than one additional year if CMS and the IRS certify the following to the DIBs:

1. The matching program will be conducted without change; and

2. The parties have conducted the matching program in compliance with this agreement.

D. Modification: The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties, provided that the changes are not significant. Significant changes require a new agreement.

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.

XIV. LIMITATIONS

The terms of this Agreement are not intended to alter, amend, or rescind any other current agreement or provision of federal law now in effect. Any provision of this Agreement that conflicts with federal law is invalid.

XV. LIABILITY

A. Each Party shall be liable for acts and omissions of its own employees.

B. Neither Party shall be liable for any injury to the other Party's personnel or damage to the other 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.

Neither Party shall be responsible for any financial loss incurred by the other, whether caused directly or indirectly through the use of any data furnished pursuant to this Agreement.

XVI. CONTINGENCY CLAUSE

This Agreement is contingent on CMS meeting the federal safeguard requirements specified in Section VIII of this Agreement. Matches with CMS under this Agreement will be suspended or discontinued immediately if, at any time, IRS determines that CMS or its contractor has failed to meet the federal safeguard requirements or any Privacy Act requirements. See the regulations at 26 CFR § 301.6103(p)(7)-1 regarding procedures for administrative review of such a determination.

XVII. PERSONS TO CONTACT

A. The IRS contacts are:

1. Project Coordinator

   Lisa C. Fowers
   Senior Data Analyst
   Internal Revenue Service
   Governmental Liaison, Disclosure and Safeguards
   Data Services
   1973 N Rulon White Blvd
   Ogden, UT 84404
   Telephone: (801) 620-7016
   Email: Lisa.C.Fowers@irs.gov

2. Safeguards and Recordkeeping Procedures

   Kevin Woolfolk
   Associate Director
   Internal Revenue Service
   Governmental Liaison, Disclosure and Safeguards
   Safeguards
   550 Main Street
   Cincinnati, OH 45202-3222
   Telephone: (513) 975-6706
   Email: Kevin.Woolfolk@irs.gov

3. Program Information

Melissa Cummings-Niedzwiecki
Special Projects Director
Wage & Investment
Individual Stakeholder Engagement and Strategy Branch
75 Perseverance Way
Hyannis, MA 02601
Telephone: (202) 603-2484
Email: Melissa.Cummings-Niedzwiecki@irs.gov

4. System Operations

Miji Matthews
Deputy Director
Submission Processing, Information Technology
NCFB
1111 Constitution Ave NW
Washington, DC 20224-0002
Telephone: (240) 613-3328
Email: Miji.A.Mathews@irs.gov

B. The CMS contacts are:

1. Program Issues

Terence Kane
Director, Division of Automated Verifications and SEP Policy
Marketplace Eligibility and Enrollment Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4449
Email: Terence.Kane@cms.hhs.gov

2. Medicaid/CHIP Issues:

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

3. Systems and Security

Darrin V. Lyles
Information System Security Officer (ISSO)
Division of Marketplace IT Operations
Marketplace IT Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: (410) 786-4744
Telephone: (443) 979-3169 (Mobile)
Email: Darrin.Lyles@cms.hhs.gov

4. Privacy and Agreement Issues

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

XVIII. APPROVALS

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. By signing this document electronically, the signatory agrees that the signature they provide has the same meaning and legal validity and effect as a handwritten signature.

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 the organization to the terms of this Agreement.

A. Centers for Medicare & Medicaid Services Program Official

Jeffrey C. Wu -S Digitally signed by Jeffrey C. Wu -S
Date: 2024.07.10 18:03:36 -04'00'

Jeffrey C. Wu
Deputy Director for Policy
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, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits the organization to the terms of this Agreement.

Sara M. Vitolo -S Digitally signed by Sara M. Vitolo -S
Date: 2024.07.12 10:45:48 -04'00'

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

Date_____

C. Centers for Medicare & Medicaid Services Approving Official

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

Leslie Nettles -S Digitally signed by Leslie Nettles -S
Date: 2024.07.16 10:48:33 -04'00'

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

Date_____

D. Internal Revenue Service Approving Official

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

Celia Y. Doggette Digitally signed by Celia Y. Doggette Date: 2024.07.26 10:36:45 -04'00'

Celia Y. Doggette
Director
Office of Governmental Liaison, Disclosure and Safeguards
Internal Revenue Service

Date 07/26/2024

XIX. DATA INTEGRITY BOARD APPROVALS

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. By signing this document electronically, the signatory agrees that the signature they provide has the same meaning and legal validity and effect as a handwritten signature.

The authorized DIB 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.

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

Cheryl R. Campbell -S Digitally signed by Cheryl R. Campbell -S
Date: 2024.08.30 12:29:10 -04'00'

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

Date_____

B. Internal Revenue Service Data Integrity Board Official

The authorized DIB 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.

Ryan A. Law Digitally signed by Ryan A. Law
Date: 2024.11.01 10:16:01 -04'00'

Ryan Law
Chairperson, Treasury Data Integrity Board
Deputy Assistant Secretary for Privacy, Transparency, and Records

Date_____

Attachment 1

Marketplace Computer Matching Programs:
Cost-Benefit Analysis

MARKETPLACE COMPUTER MATCHING PROGRAMS: COST-BENEFIT ANALYSIS

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

COST-BENEFIT ANALYSIS FOR MARKETPLACE MATCHING PROGRAMS

Updated March 29, 2024

Table of Contents

Introduction

This cost benefit analysis (CBA) provides information about the costs and benefits of conducting the eight required Marketplace[1] matching programs, which are conducted under matching agreements between the Centers for Medicare & Medicaid Services (CMS) and each federal data source agency, and between CMS and state administering entities (AEs). The objective of the Marketplace matching programs is to support the enrollment of eligible individuals in appropriate health coverage programs, thereby reducing the uninsured population and improving overall health care delivery.

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

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

While the matching programs support accurate eligibility determinations, which help avoid improper payments (e.g., improper payments of tax credits to ineligible individuals), no data is available to quantify the amount of improper payments avoided. In addition, the match results are not currently used to identify or recover past improper payments. Consequently, there are no estimates of avoided or recovered improper payments in key elements 3 and 4 (i.e., the "benefits" portion) of the CBA to offset against the personnel and computer costs estimated in key elements 1 and 2 (i.e., the "cost" portion) of the CBA. As a result, the four key elements of

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

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

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

Costs

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

For Agencies –

- **CMS (Recipient Agency):** $52.2 million ($2.2 million internal costs; $50.0 million external costs) per year.
- **Source Federal Agencies:** $19.8 million per year (reimbursed by CMS)
- **State AEs:** No data developed.
- **Justice Agencies:** Not applicable, as these matching programs are not currently used to detect and recover past improper payments and therefore do not generate collection cases for justice agencies to investigate and prosecute.

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

- Opportunity costs (time required to apply for coverage) are quantified as $1.1 billion per year ($51.83 per application x 21.3 million consumers enrolled in QHPs).

For the General Public –

- No data developed. Costs to the public (such as discouragement of legitimate potential participants from applying, threats to privacy, constitutional rights, and other legal rights) would be less significant in these matching programs than in other matching programs, because these matching programs are intended to support enrollments and are not currently used to detect and recover past improper payments.

Benefits

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

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

Matching Program Structure

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

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

Without the Hub, each State AE would be required to enter into a separate arrangement with each federal agency to determine whether applicants for state health subsidy programs are eligible for coverage. If the match operations were conducted through separate arrangements outside of the Hub, the costs to CMS, the source federal agencies, the AEs, and consumers (applicants) would be significantly greater than under the current structure.

Background assumptions

CMS has made the following assumptions in developing this CBA:

- The ACA does not expressly mandate the use of computer matching, but effectively requires it by requiring a single streamlined application process for consumers. Because matching must be conducted to provide the single, streamlined application process Congress required (i.e., is not optional), this CBA does not evaluate whether the matching programs should be conducted versus not conducted, but rather it evaluates whether the matching programs are efficiently structured and conducted, and whether the current structure is less costly than an alternative structure.
- Eight matching programs are currently operational. CMS receives data from seven source federal agencies (IRS, DHS, SSA, OPM, Peace Corps, VHA, and DoD) under separate CMAs. Under an eighth CMA, CMS makes the data from those seven source federal agencies, as well as CMS data regarding Medicare enrollment, available to state AEs; in addition, the eighth CMA makes state Medicaid and CHIP enrollment data available to CMS. The seven source federal agencies, CMS, and the state AEs are collectively known as the trusted data sources (TDSs). All data from the TDSs are accessed by CMS and by state AEs via the Hub platform, rather than via direct access from any AE to any TDS.
- Any alternative, non-Hub structure that could be used instead of the current Hub structure would require many more than eight CMAs, as well as many more system interconnections and data transmissions between agencies.
- For a subset of the TDSs, CMS incurs a cost as the recipient agency. The cost of each data transaction is estimated based on a prior year's matching program budget and the estimated number of data transactions occurring that year.
- In addition to the TDSs themselves, additional entities are necessary to provide support services to the Hub. CMS therefore incurs external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub. In addition, costs are incurred for identity proofing of applicants, troubleshooting, procedure writing, and maintenance support.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the Hub and the matching programs.
- The benefit of these matching programs is to consumers who apply for and obtain health coverage. The private benefit to them is improved health care delivery and the expected value of the coverage (whether through private insurance, Medicaid, CHIP or a Basic Health Plan).
- Regarding the Recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.

I. Costs

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

Internal CMS Costs - $2.2 million / year

Most costs paid by CMS to implement the Marketplace matching programs and the Hub are external costs paid to contractors, which are addressed in the next section. CMS' internal costs for federal staff tasked to work on these programs are approximately $2.2 million per year. The below chart attributes all of the costs to federal staff working in the Center for Consumer Information and Insurance Oversight (CCIIO) office; however, many teams across CMS provide support to the implementation of these programs, and CCIIO staff often have other programs in their portfolios beyond the Marketplace matching programs and the Hub.

CCIIO Team	Estimated Annual Cost
Marketplace Eligibility and Enrollment Group (MEEG)	$799,900
State Marketplace and Insurance Programs Group (SMIPG)	$342,814
Marketplace Information Technology Group (MITG)	$1,028,443
Total	$2,171,157

External CMS costs: Hub operations – an undetermined portion of $50.0 million/ year

- The Hub – a portion of $25.5 million / year
  The Hub is maintained by a CMS contract. While the initial build costs of the Hub were largely incurred before the implementation of the Marketplace programs in 2013, there are ongoing costs associated with system maintenance, changes necessitated by ongoing technology development and new program implementation, and general system health monitoring. In FY2024, the average annual cost of the Hub contract was $25.5 million. The Hub supports many other Marketplace program efforts besides the matching programs, including the transmission of data to and from insurance issuers, and electronic file transfer for many programs within the Marketplace; as a result, $25.5 million is an overestimate of the annual Hub costs associated with Marketplace matching program operations.

- Marketplace Security Operations Center (SOC) – $2.9 million / year

  The Marketplace SOC is responsible for the security operations and maintenance for the Hub and the Federally-facilitated Marketplace (FFM). The current cost of the Marketplace SOC work is $2.9 million per year. However, because the Marketplace SOC budget is not formally delineated for the Hub and for the FFM, the cost cited above is an overestimate of the costs specific to supporting Hub operations.

- Exchange Operations Center (XOC) - $15.0 million / year

  The Exchange Operations Center (XOC) is an entity managed under the Marketplace System Integrator contract tasked with coordinating the technical operations of the Hub and of the FFM. The XOC supports system availability, communication of system issues to stakeholders, and incident triage. Because the XOC budget line is not formally delineated for the Hub and for the FFM, the operational cost cited above is an overestimate of the costs specific to supporting Hub operations. The $15.0 million cost estimate provided here covers both XOC operations as well as site reliability engineer and metrics costs in support of the XOC.

- Identity-Proofing Service Costs – $6.6 million / year

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

Costs paid by CMS to TDS agencies – $19.8 million / year

- SSA - $3.4 million / year

  The SSA is the source of numerous data elements for the Hub: verification of the applicant's name, date of birth, citizenship, Social Security Number (SSN), a binary indicator for incarceration, Title II income (retirement and disability), and work quarters. Verification of an individual's SSN is a required precursor to accessing consumer information through the other Marketplace matching programs.
  Matching with SSA data is accomplished through a reimbursable agreement with CMS. The total cost of the SSA contract with CMS in FY 2024 was $3,354,895 under IAA number IA24-06.

- DHS – $15.3 million / year

  DHS is the verification source for naturalized and derived citizenship, and immigration status. The total cost of the DHS contract with CMS in FY 2024 is $15,246,409 under IAA number IA24-10.

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

- VHA - $1.1 million / year

  Data from the VHA are used to identify current enrollment in health coverage through the VHA, which is an eligibility factor for APTC and cost sharing reduction (CSR) programs. The VHA contract with CMS is transactions-based. The total cost of the VHA contract with CMS in FY 2024 is $1,098,622 under IAA number IA24-08.

- Office of Personnel Management - $24,000 / year

  For FY 2024, OPM charged CMS a flat fee of $24,000 under IAA number IA24-09.

- Other Trusted Data Sources

  CMS does not pay the other Trusted Data Sources (IRS, DoD, Peace Corps, and State Medicaid and CHIP Agencies) for access to and use of their data.

Consumer opportunity costs – non-monetary, but quantified

Applying for coverage does not have a monetary cost to applicants, but does have an opportunity cost. CMS estimates that the average time for a consumer to apply for and enroll (or re-enroll) in a QHP each year averages 1.5 hours.[2] At a rate of $34.55 per hour, this opportunity cost is estimated at $51.83 per application per year. The complete number of applications submitted each year across all AEs is not known, but the total number of QHP enrollees for Plan Year 2024 is 21.3 million,[3] resulting in a consumer opportunity cost of approximately $1.1 billion. It should be noted that this estimate does not include opportunity costs for enrollees in Medicaid, CHIP, or BHP programs, or for consumers who apply but do not subsequently enroll in coverage.

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

[3] Enrollees in QHPs have the opportunity each year to be automatically reenrolled in a QHP or to return to the Exchange to choose a new plan – however, Marketplaces encourage enrollees to update their information and reevaluate their health coverage needs for the coming year. Furthermore, enrollees are required to report certain life changes as they occur, since they may impact coverage and/or participation in insurance affordability programs. CMS has elected to use the entire universe of 2024 QHP enrollees (21.3 million) in this CBA in order to present the most conservative case for consumer opportunity costs.

II. Benefits

Benefits to Agencies – not quantified

The Marketplace matching programs improve the accuracy of data used for making program eligibility determinations, and ensure that individuals are correctly determined and are not inappropriately enrolled in multiple programs. Improved data quality helps ensure that eligibility determinations and other decisions affecting APTC are accurate, which helps avoid future improper payments. This avoidance of future improper payments fits the third cost benefit analysis key element but hasn't been quantified.

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

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

For Plan Year 2024, 21, 310, 538 consumers enrolled in a QHP across all Marketplaces. Of these, 90% receive APTC, with an average value of $537 per month (annualized to $6,324 per year). In total, therefore, approximately $121.3 billion in APTC will be provided to enrollees in Plan Year 2024.[4]

Approximately 51% of the QHP enrollees in Plan Year 2024 receive financial assistance through cost-sharing reductions when enrolling in a silver-level plan. The financial estimate of this benefit is not quantified here, as it is dependent on individual utilization of medical services. Additionally, a significant number of consumers receive health coverage through Medicaid, CHIP, or a BHP, and received eligibility determinations for that coverage based on data made available through these agreements. Because of the wide variety in state approaches to making and reporting eligibility determinations, the number of enrollees in these programs is not quantified here.

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

[4] https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-final-national-snapshot

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

Recovery of improper payments – not an objective at this time

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

Consideration of Alternative Approaches to the Matching Programs

In requiring a single, streamlined application process and specifying electronic data access, the ACA effectively required use of computer matching to make eligibility determinations. As a result, wholly manual alternatives for verification of application information (such as a paper-based documentation process) are not considered as a viable alternative in this analysis.
The Marketplace matching programs currently leverage the Hub to minimize connections between AEs and the federal partners. This model has successfully met program needs by providing for a single streamlined application process for consumers, and supporting accurate eligibility determinations, which in turn increase program integrity for the Marketplace programs.

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

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

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

Conclusion

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

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

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