DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: August 11, 2020

TO: All Medicare Advantage, Prescription Drug Plan, Cost, PACE, and Demonstration Organizations

FROM: Jerry Mulcahy
Director

SUBJECT: Enrollment Guidance Policy Changes and Updates and Model Medicare Advantage and Prescription Drug Plan Individual Enrollment Request Form for Contract Year 2021

The Centers for Medicare & Medicaid Services (CMS) is issuing Medicare Advantage (MA), Prescription Drug Plan (PDP), and §1876 Cost Plan Enrollment and Disenrollment Guidance revisions for contract year 2021. These updates primarily reflect revisions resulting from final regulations published on June 2, 2020, in CMS-4190-F (Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program). To implement these changes, we updated guidance to Chapter 2 and 17D of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.

CMS is also announcing the release of the new Model Individual Enrollment Request Form to enroll in an MA or Part D plan, OMB No. 0938-1378. CMS revised and improved the standard ("long") model form used for MA and PDP enrollment to the new "shortened" form to simplify the enrollment process.

All enrollments with an effective date on or after January 1, 2021, must be processed in accordance with the revised guidance requirements, including the new model MA and PDP enrollment form. MA and Part D plans are expected to use the new model form for the 2021 plan year Annual Enrollment Period (AEP) which begins on October 15, 2020.

Significant changes to the guidance include:

1. Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries

Effective for the plan year beginning January 1, 2021, CMS removed the prohibition on beneficiaries with ESRD enrolling in an MA plan. Plans can accept and process elections made by ESRD beneficiaries that choose to join an MA plan during a valid election period.

2. Special Election Periods (SEPs) for Exceptional Conditions

CMS codified a number of SEPs previously adopted and implemented through subregulatory guidance as exceptional circumstances SEPs. We also established two new SEPs for exceptional circumstances:

SEP for Individuals Enrolled in a Plan Placed in Receivership
CMS established new SEPs, at §§ 422.62(b)(24) and 423.38(c)(31), for individuals enrolled in plans that are experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.

SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer
CMS established new SEPs, at §§ 422.62(b)(25) and 423.38(c)(32), for individuals who are enrolled in plans identified with the low performing icon (LPI) in accordance with §§ 422.166(h)(1)(ii) and §423.186(h)(1)(ii), respectively.

3. Medicare Advantage and Prescription Drug Plan Model Enrollment forms

CMS revised and improved the standard ("long") model form used for MA and PDP enrollment to a new streamlined form. The new model enrollment form (see Attachment 1), requires the minimal amount of information to process the enrollment, and other limited information that the sponsor is required or chooses to provide to the beneficiary[1].

The new model form consists of the following parts outlined below:

1. Cover Page
The cover page includes information for the beneficiary on Medicare enrollment and instructions to complete the enrollment form.

2. Model Enrollment Request Form
Section 1 includes data elements required to process the beneficiary's enrollment.

Section 2 includes mandatory data elements that the plan is **required** to include on the application and optional data elements which the plan is **not required** to include. All data elements in Section 2 are **optional** for the beneficiary to complete. Plan enrollment will not be affected if the beneficiary does not complete this additional information.

Mandatory Data Elements: Beneficiary language or accessible format preference[2].

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[1] Requests for enrollment must comply with all requirements outlined in 42 CFR 422.2262 and 423.2262 and be approved by CMS.

[2] Organizations are required to provide information to individuals in accessible/alternate formats (e.g., Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973. CMS will allow plans

Optional Data Elements: Information that a plan may determine to be useful in processing an enrollment request, including options for beneficiary premium payment, choice of primary care physician (where applicable), or other information determined useful by the sponsor.

Electronic Delivery of Plan Specific Materials
Section 2 also allows plan sponsors to list those categories of materials available for electronic delivery.

The OMB-approved enrollment form is considered a "model" for purposes of CMS review and approval of plan marketing materials; and plans can choose to customize the form as needed.

4. Additional Updates

Model Notice update
We removed information from Chapter 2 Exhibit 22 regarding the option to use an SEP to disenroll from the plan due to the loss of optional supplemental benefits due to nonpayment of optional supplemental premiums. An individual would be able to disenroll only if s/he is eligible for one of the existing SEPs.

Electronic Signatures
As part of the Electronic Enrollment process, plan sponsors are afforded the flexibility to accept electronic signatures from a beneficiary that affirms his/her intent to complete the enrollment. We added language that allows plan sponsors to obtain an electronic signature as an alternative to the "Enroll Now" or "I Agree" button or tool used in completing an Electronic Enrollment request. This change only applies to the Electronic Enrollment mechanism. The affirmation requirements for the Telephonic and Paper Enrollment mechanisms remain the same.

An electronic signature is considered to have the same legal effect and validity as a pen-and-ink signature. An organization utilizing electronic signatures must, at a minimum, comply with the CMS security policies. The requirements for legally binding electronic signatures can be found in the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001.

Updates are incorporated into the contract year 2021 enrollment guidance. The revised guidance chapters, in their entirety, will be posted at the links below within 5 business days of this memorandum. Additionally, a summary of changes that outlines the sections that have edits and basic information on what has changed is also available at the links below.

- MA and Cost Plan enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and- Enrollment/MedicareMangCareEligEnrol/index.html
- PDP enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html

to determine the formats they can provide, such as qualified readers, interpreters (not language interpreters). In addition, per Title VI of the Civil Rights Act of 1964, Section 4302 of the Affordable Care Act and 42 CFR 422.2268(a)(7), 423.2268(a)(7), the sponsor must take reasonable steps to make the enrollment application accessible to individuals with limited English proficiency.

Please direct questions regarding the submission of enrollment forms and enrollment policy first to your CMS Account Manager. If you need additional assistance, please submit your inquiry to Division of Enrollment and Eligibility Policy mailbox at https://enrollment.lmi.org and copy your CMS Account Manager.

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EXHIBIT 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
<Plan Name>
<Plan address>
<Plan address>
<Plan address>

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call <Plan Name> at <phone number>. TTY users can call < phone number >.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a <Plan Name> al <phone number/TTY> o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Product ABC – $XX per month ☐ Product XYZ – $XX per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

[*MA-PD / PDPs insert:*
Will you have other prescription drug coverage (like VA, TRICARE) in addition to < Plan>? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage

_____ _____ _____]

[Special Needs Plans] insert question(s) regarding the required special needs criteria]

IMPORTANT: Read and sign below:

- [*MA plans insert:* I must keep both Hospital (Part A) and Medical (Part B) to stay in <Plan Name>.]
- [*Part D plans insert:* I must keep Hospital (Part A) or Medical (Part B) to stay in <Plan Name>.]
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- [*MA plans insert:* I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered.]
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

[☐ Plans insert the languages required in your service area.]

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact <plan name> at <phone number> if you need information in an accessible format other than what's listed above. Our office hours are <insert days and hours of operation>. TTY users can call <TTY number.>

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

☐ [*Plans may list those types or categories of materials that are available for electronic delivery]*

E-mail address:

Paying your plan premiums

[Plans with premiums insert: You can pay your monthly plan premium [*MA-PD plans with premiums insert:* (including any late enrollment penalty that you currently have or may owe)] by mail <*insert optional methods*: "Electronic Funds Transfer (EFT)", "credit card"> each month <*insert optional intervals, if applicable, for example* "or quarterly">. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**]

[*MA-PD and PDPs with premiums insert:* **If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.