#	Common Theme	Commenters																										Summary of Comment	Proposed Reponses
		Anonymous (7 listed Anonymously)	America's Health Insurance Plans (AHIP)	Anthem	Banner University Health Plans	Blue Cross Blue Shield of Massachusetts (BCBSMA)	Blue Cross Blue Shield Michigan (BCBSM)	Blue Cross Blue Shield of Tennessee (BCBST)	CVSHealth	Fallon Health	Health Care Service Corporation (HCSC)	HealthPartners	Highmark Inc. ("Highmark")	Humana	Kaiser Permanente (KP)	Kyle McMillan	Linda Gallagher	MH Life Insurance, Inc.	Providence Health Assurance (PHA)	Triple-S Advantage, Inc.	UnitedHealthcare (UHC)	Unknown Organization	WellCare	William Ilgenfritz					
1	Value Added Information								X																			One commenter requested that CMS define value-added information.	The new model enrollment form includes items required, under federal law, to determine a beneficiary's eligibility for plan enrollment. The enrollment form may also include optional items, such as (paying your plan premiums), which aids the sponsor to efficiently process the request and set up beneficiary preferences for services. We proposed to call this information "value-added information." However, to avoid confusion with the term, "value-added services", which plans may offer to better support members' needs, we decided to delete this language from the form.
2	Final Enrollment Guidance and Enrollment Application Release Dates	X							X						X						X							Several commenters expressed concern about the timing for the release of the model form. One commenter recommended that CMS offer sponsors a minimum of 90 days, to incorporate and operationalize changes to the enrollment form. Another commenter proposed that, on an annual basis, CMS release the final Enrollment Guidance in April of the preceding plan year to take into account the technology and process updates necessary to make the changes outlined in the Enrollment Guidance. The commenter notes that the steady increase in Medicare Advantage (MA) membership has led to an increase in the number of materials to develop which strains production timelines. The commenter strongly recommends earlier release dates, as well as increased communication from CMS on release timelines and status updates if guidance or models will be late.	CMS appreciates the suggestions and concerns expressed by these commenters, and agrees that plans should be given adequate time to implement system updates. We plan to release the new model MA and Part D enrollment form by or before June 2020, which we believe will afford plans adequate time to make the changes necessary prior to the Annual Enrollment Period.
3	Flexibility in Customizing the Enrollment Form	X	X	X	X				X	X				X					X	X			X					We received a number of comments on plans ability to customize the enrollment form as needed, once it is OMB approved and finalized by CMS. Two commenters suggested that plans retain the ability to submit the enrollment form as non-Model, for modifications specific to plan processes. Another commenter asks if sponsors are limited on the amount of information the plan can request for operational purposes. Many commenters requested the flexibility to include optional language that allows branding (i.e. plan specific information), on the enrollment form, such as the plan's name, logo, and contact information. In addition, the commenters stated that the instructions page should allow plans to add information on where to mail the completed application, and how to enroll by phone or online, in lieu of paper form. Two commenters suggest we add the "For office use only" box to the bottom of the form.	CMS appreciates these comments and agrees with allowing plans the flexibility to include plan specific information. Under federal law, the enrollment form is considered a "model" for purposes of CMS marketing review and approval; therefore, MA and Part D plans are able to modify the language, content, format, or order of the enrollment form as noted in the Medicare Communications and Marketing Guidelines (MCMG).
4	Reference to mandatory addendum	X	X	X					X		X																	Several commenters recommended that we remove the mandatory addenda language and use beneficiary-friendly language to promote clarity. Two commenters recommended incorporating the mandatory language in separate instructions to plans to eliminate confusion to beneficiaries. We received another comment that requested we explain if the referenced header and note are part of the model form, or if the language serves as instructions to the plan.	We included references to the mandatory addendum with a dual-pronged approach to 1) inform sponsors of the required data fields (race and ethnicity data) which are now part of the new model enrollment form and 2) inform beneficiaries that a response is optional. We agree with the recommendations received and removed instructions that addressed plan requirements in the mandatory addendum. We provided instructions solely to the beneficiary for completing the form that explains both optional and required fields necessary to enroll in the plan. These instructions also inform applicants that coverage can't be denied if the optional fields are not completed.
5	Things to Remember-Signing up during open enrollment	X				X													X		X		X					One commenter requested that CMS clearly communicate that plans must receive the enrollment application by December 7. The commenter recommends that sponsors need to receive mailed applications two weeks before the end of the AEP given mail volumes in December. The commenter further suggests we consider adding language to contact the plan to find out alternate enrollment options to ensure receipt of the application prior to December 7. Another noted that the current language gives the impression that the plan will accept an application mailed by or on December 7 causing the enrollment to reject unless CMS plans to change the definition of the "Application date" in guidance. A commenter preferred we changed the bullet to reflect the Annual Enrollment Period (AEP) as opposed to the Open Enrollment Period (OEP) since the Medicare Advantage Open Enrollment Period (MA-OEP) occurs from January 1 – March 31.	We appreciate the comments but disagree with the commenter that proposes that the enrollment request cut-off occur two weeks in advance of the close of the Annual Enrollment Period (AEP) for mailed paper applications. The AEP, as required under federal law, is available from October 15 – December 7 in which eligible individuals can join an MA or Part D plan. CMS will maintain the current definition of the "application date" in sub regulatory guidance that states that for requests sent by mail, the application date is the date the application is received by the organization (i.e., arrives in the organization's mailbox or mailroom); the postmark is irrelevant).

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6	Name of Plan to Enroll	X							X	X			X		X				X	X					A few commenters preferred having the option to list all plans available and the beneficiary selecting his or her plan of choice using with a check box. Another commenter asked if CMS would consider adding the option to check the plan name that lists the plan's premium to help reduce beneficiary errors/mistakes. Another stated that the removal of the list of plans/premiums from which a beneficiary can choose creates the potential to: 1) result in increased outbound calls by plans, and 2) beneficiaries not truly grasping the cost associated with their chosen plan.	We thank the commenters and made changes to the form to include check box options with the plan's name and costs associated for the reasons outlined by the commenters.
7	Removal of ESRD language	X				X	X	X							X										A few commenters questioned whether the removal of the ESRD question was indicative of a CMS policy change related to ESRD and MA plan eligibility for 2021. Another commenter requested that CMS confirm that the ESRD question was removed because ESRD will no longer be a factor in determining MA eligibility as of CY 2021 due to the 21st Century Cures Act. Another commenter, though in favor of removing the ESRD question from the enrollment form, requested further guidance regarding how CMS expects ESRD statuses to be confirmed and reconciled. The commenter states that plans are currently able to identify ESRD status at the time of enrollment and post enrollment via CMS records and health plan records, and hopes to understand how removing the ESRD question will impact the way ESRD information must be obtained/reconciled in order to ensure appropriate payment. Another commenter wanted to understand how the plan would know, once the ESRD question was removed, when to complete a plan denial upon an unsuccessful transplant? One commenter suggested keeping the ESRD question should the member have ESRD but it is not reflected in CMS systems.	The 21st Century Cures Act, removed the prohibition for ESRD beneficiaries to enroll in an MA plan, effective plan year 2021. CMS issued a notice of proposed rulemaking in February 2020, which proposes to codify this change in federal regulation. The removal of the ESRD question from the enrollment form does not affect how we calculate ESRD payments. Plans will continue to receive the Daily Transaction Reply Report (DTRR), which would tell them if an individual no longer has ESRD. The DTRR identifies whether a beneficiary submission was accepted or rejected and provides additional information about plan membership. It also includes an ESRD Indicator field, which indicates whether the beneficiary has ESRD. In addition, the proposed rulemaking also discusses how plans would be paid for ESRD beneficiaries. The Advance Payment notice also released in February 2020 and currently in the public comment period, details payment information for ESRD beneficiaries in MA plans for 2021. The Advance Payment notice comment period closes in early March 2020; the regulation (CMS-4190-P) comment period closes early April 2020.
8	Race and Ethnicity Data	X							X						X			X						X	Several commenters question CMS' intended use of the race/ethnicity data, since it is included on the enrollment form. Another commenter asks if CMS expects plans to include this data on enrollment transactions or just retain should CMS inquire about it. In addition, whether CMS plans to add it to mandatory reporting items such as the Part C/D enrollment/reporting requirements. Several commenters question the timing and format of reporting, if required by CMS. Including, if non-responses/declinations should be reported. Plans want to consider the relative cost and level of effort to record and store this information in Plan systems, (which could be significant for some), against what CMS intends to do with it so that Plans can properly plan for the collection and storage of this data. Another commenter believes this information is not useful for plans to collect since it has no impact on beneficiary enrollment. Yet, another commenter supports the inclusion of this field as it aligns with efforts of their organization to collect this data through their care delivery system and thereby help create familiarity with this practice on the part of the beneficiary prior to formally joining their plan. However, several commenters strongly recommend that CMS maintain the field as optional, so as not to deter enrollment and/or influence plan choice for beneficiaries who may prefer not to share this information. Few commenters question whether applicants need to respond to the race/ethnicity data questions. A few believe that some beneficiaries may view it as discrimination or inequitable treatment, and possibly pointing to that, if they subsequently have a less-than-desirable experience with the Plan or Medicare at some point. One commenter believes it is not appropriate to ask, and can be seen as either discriminatory or cherry-	We appreciate the concerns expressed by the commenters; however, CMS plans to develop a strategic plan to address Congress' expressed interest in our collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures. Currently, no source of available data for all Medicare beneficiaries is compliant with the HHS Data Collection Standards for race and ethnicity data. We are therefore collecting race and ethnicity data in the format that conforms with the 2011 HHS Data Standards for person-level data collection, while also meeting the 1997 OMB minimum data standards for race and ethnicity. As the information is optional for the beneficiary to complete, we do not believe that non-responses/declinations need to be included on the form. If we plan to make this reporting mandatory, we will propose the requirements through the public comment process. We do not believe that this would be a tremendous cost to the plans, as we understand that some organizations collect this information to understand the populations they serve. However, CMS will work to minimize the administrative burdens of data collection and reporting on health plans. Furthermore, we anticipate that the expanded 2011 HHS Data Standards format will provide improved granular information for plans and CMS to use to understand the populations they serve. It is not our intention to collect this data to impact enrollment and/or influence plan choice for beneficiaries. We believe, and research consistently shows, that improving how race and ethnicity data are collected is an important first step in improving quality of care and health outcomes.
9	Attestation for Eligibility of an Enrollment period	X		X					X			X	X		X				X						We received several comments to clarify if plans will be able to incorporate the Attestation of Eligibility for an Enrollment Period (Exhibit 1a) within the enrollment request form. If allowed, for CMS to specify where within the form to include this information. One commenter asks that CMS clarify if a separate exhibit still exists for attestations. Another recommends CMS add Exhibit 1a to this proposed form to help plans meet the 7 day timeliness requirement to determine whether an applicant has an election available. Another asked whether the model form could include the attestation as optional.	The proposed changes to the current enrollment request form serve to make the form more "beneficiary-focused" and to "simplify the enrollment process." Separate from determining whether an enrollment request is complete; sponsors need to determine an individual's eligibility for an election period. While this information can be supplied through Exhibit 1a (Attestation of Eligibility for an Enrollment Period), it is available for plans to use with the enrollment request to reduce plan burden and assist with the timeliness requirement. Plans, therefore, have the option to include this information within the enrollment request form.
10	File and Use Requirement								X																A commenter recommends that the enrollment forms follow the same guidance as the Summary of Benefits and be permitted to be filed as a 10-day File & Use instead of a 45-day for non-model due to timing issues. The commenter mentioned that member friendly changes (such as reordering sections, adding questions/images) requires them to file their forms as non-model, which presents challenges in terms of timing.	We will consider this comment as we look to changes in the HPMS Marketing Module.

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11	Frequently Asked Questions- Section																								A commenter stated that the number of CMS-required materials and disclaimer pages that MA plans and Part D sponsors must include in their enrollment kits has become lengthy and requires that MA plans and Part D sponsors maintain multiple versions based on plan type. The amount of information that is presented can result in beneficiary confusion. The commenter recommends that the FAQs only include general questions that are applicable to all plan types in order to reduce the number of versions that MA plans and Part D sponsors must maintain. The commenter also recommends that CMS limit these questions to those that are extremely relevant at the point of enrollment (e.g., enrollment period dates, who is eligible to apply, etc.). Additionally, they propose that CMS eliminate the Pre-Enrollment Checklist (MCMG Appendix 3) in order to help reduce duplicative/redundant information already contained in the new FAQ section.	We try to strike a balance with the materials (and disclaimers) provided to beneficiaries with an enrollment form. We have drastically decreased the size of the Summary of Benefits (SB) and the creation of the Pre-Enrollment Checklist allows us to reduce the number of required material disclaimers, while ensuring the beneficiary is provided critical information prior to making an enrollment decision. These materials have been created with feedback gathered from industry, advocates, and beneficiaries via consumer testing.
12	Required Statements on all Enrollment Mechanisms																		X						One commenter questioned whether the removal of the required elements provided in model language in sub regulatory guidance that must be included on enrollment request mechanisms within the "Please Read and Sign Below" and acknowledged by beneficiaries would be updated in guidance to reflect that it is no longer a requirement. The commenter asked whether CMS plans to update the required elements, such as the requirement to keep Medicare Parts A and B, understanding that an enrollee can only enroll in one Medicare health plan at a time and the right to appeal service and payment denials, to reflect the changes in the proposed enrollment request form	We appreciate the comments. CMS will update sub regulatory guidance consistent with the requirements under federal law for election forms and other election mechanisms completed by MA or Part D eligible individuals. We also note that the enrollment form is considered a "model" for purposes of CMS marketing review and approval; therefore, MA and Part D plans are able to modify the language, content, format, or order of the enrollment form as noted in the Medicare Communications and Marketing Guidelines (MCMG).
13		X							X		X							X							One commenter asked about our expectations in having the beneficiary write in their preferred spoken and written language. The commenter expressed concern that the member will expect all plan communications in the language they choose, which could be outside of the 5 percent threshold list that CMS provides. The concern extended to the downstream operational affects if languages outside the approved threshold are required to be provided/prepared and the time needed to implement system updates and translation processing times. Another commenter recommended that CMS consider including a list of available languages and list of accessible formats from which the applicant can choose (i.e., by checking a box), which may better support beneficiary efforts to populate the form as well as increase clarity. Another commenter suggested we tailor the section specifically for those individuals needing alternate formats or languages other than English so that not every applicant would need to fill in this section. One commenter requested we clarify the section, as the current text seems to suggest that a list of languages appears above. Another believed that the way it is phrased/formatted, might create inaccurate requests. Another commenter questioned CMS' intent on the use of this information and the requirement for additional formats. Another commenter suggested we tailor the section specifically for those individuals needing alternate formats or languages other than English so that not every applicant would need to fill in this section.	We thank you for the comments. Organizations are required to provide information to individuals in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973 (and subsequent revisions). Such individuals must have an equal opportunity to participate in enrollment, paying premium bills, and communicating with the plan, as members who do not request accessible/alternate formats. Based on the comments, we revised the enrollment request form to accommodate information in language(s) other than English and language(s) required in the plans service area.
14	OMB Control Number								X																One commenter requested we clarify whether the OMB control number with the expiration date is now required on the enrollment form.	We thank you for your comment. Plans are not required to place the OMB control number and the expiration date on the enrollment form.