Supporting Statement Part A
Model Medicare Advantage and Medicare Prescription Drug
Plan Individual Enrollment Request Form
(CMS-10718, OMB 0938-1378)

Background

Section 4001 of the Balanced Budget Act of 1997 (Public Law 105-33) enacted August 5, 1997, established Part C of the Medicare program, known as the Medicare + Choice program, (now referred to as Medicare Advantage (MA)). As required by 42 CFR 422.50(a)(5), an MA eligible individual who meets the eligibility requirements for enrollment into an MA or MA-PD plan may enroll during the enrollment periods specified in §422.62, by completing an enrollment form with the MA organization or enrolling through other mechanisms that the Centers for Medicare & Medicaid Services (CMS) determines are appropriate.

Section 101 of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108–173) enacted December 8, 2003, established Part D of the Medicare program, known as the Voluntary Prescription Drug Benefit Program. As required by 42 CFR 423.32(a) and (b), a Part D-eligible individual who wishes to enroll in a Medicare prescription drug plan (PDP) may enroll during the enrollment periods specified in §423.38, by completing an enrollment form with the PDP, or enrolling through other mechanisms CMS determines are appropriate.

The current collection of information as required by 42 CFR 422.50, 422.60, and 423.32 was originally approved under OMB Control No. 0938-1378 (CMS-10718) on July 17, 2020. It incorporated changes to the previous standard (“long”) model enrollment form (used by both MA and PDP sponsors) which yielded a new “shortened” model enrollment form.

As further explained in sections 12 and 15 of this Supporting Statement, we are updating this collection of information request to account for changes to the number of Medicare-eligible beneficiaries estimated to make a valid enrollment request for calendar year (CY) 2021 through 2023 as set out in our June 2, 2020 final rule (CMS-4190-F, RIN 0938-AT97) to include the MA Plan Options for End Stage Renal Disease (ESRD) Beneficiaries (§§422.50, 422.52, and 422.110) and the Contracting Standards for Dually-Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514).

A. JUSTIFICATION

1. Need and Legal Basis

The general authority for requiring this data collection for MA plan enrollment is section 1851(c) – (2)(A) of the Act, and implementing regulations at §§ 422.50 and 422.60.

The general authority for requiring this data collection for PDP enrollment is section 1860D-1(b)(1)(A) of the Act, and implementing regulations at §§ 423.30 and 423.32.

The enrollment form is considered a "model" under Medicare regulations at §§422.2262 and 423.2262, for purposes of communication and marketing review and approval; therefore, MA and Part D plans are able to modify the language, content, format, or order of the enrollment form. The optional questions, which aids the MA and Part D plan in processing the enrollment, is developed for efficiency for the plan. Plan sponsors can obtain information at the initial point of contact to help streamline the beneficiary's enrollment process. The optional questions include information, specific to the plan's business needs that will reduce overall burden and allow for timely processing of an enrollment request. Sponsors are not required to include the optional data fields and if included, the beneficiary is not required to respond and plan enrollment will not be affected.

2. Information Users

MA and PDP organizations, applicants to MA and PDP organizations, and the CMS will use the information collected to comply with the eligibility and enrollment requirements for Medicare Part C and Part D plans.

CMS expects MA and PDP organizations to ensure the enrollment form complies with CMS' instructions regarding content and format. New and current enrollees that utilize the enrollment form to elect an MA or Part D plan must acknowledge the requirement to: (1) maintain Medicare Part A and B to stay in MA or Part A or B to stay in Part D; (2) reside in the plan's service area; (3) make a valid request during a valid election period; (4) follow plan rules; (5) consent to the disclosure and exchange of information between the plan and CMS; and (6) enroll in only one Medicare health plan and that enrollment in the MA or Part D plan automatically dis-enrolls him/her from any other Medicare health plan and prescription drug plan.

CMS will also use this information to: expedite the exchange of enrollment data with MA and PDP organizations, track beneficiary enrollment, improve proper payment for services provided, and to ensure that correct information is disclosed to Medicare beneficiaries, both potential enrollees and current enrollees.

Medicare beneficiaries will use the information provided by the MA and Part D sponsors to make decisions regarding MA and Part D enrollment as well as grievance and appeal requests.

3. Use of Information Technology

MA organizations and Part D sponsors must have, at a minimum, a paper enrollment form process (approved through the CMS marketing material review process described in the *Medicare Communications and Marketing Guidelines*) available for potential enrollees to elect enrollment in a MA or PDP plan.

Where feasible, the collection of information involves the use of automated, electronic, telephonic, mechanical, or other technological collection techniques designed to reduce burden and enhance accuracy.

To comply with the Government Paperwork Elimination Act (GPEA), the following information is provided:

Plans may develop and offer electronic enrollment mechanisms made available via an electronic device or through a secure internet website. Plans also have the option of obtaining technical support, (e.g. licensed software) and related services from downstream entities, such as a broker or third-party website, as a means of facilitating and capturing the electronic enrollment request.

CMS holds plans responsible for ensuring that:

(1) Enrollment policies outlined in *Chapter 2 - Medicare Advantage Enrollment and Disenrollment* and *Chapter 3 – Part D Eligibility, Enrollment and Disenrollment* are followed, and

(2) There is appropriate handling of any sensitive beneficiary information provided as part of the online enrollment.

4. Duplication of Similar Information

This collection does not contain duplication of similar information.

An enrollment request mechanism (i.e. paper, electronic) is required for the plan to identify a beneficiary's expressed interest to join a plan and consequently for the plan to know that an enrollment is requested.

CMS receives information on individuals entitled to social security benefits and automatically enrolled in FFS; however, individuals not entitled to these benefits even if they are eligible for Medicare based on age, are not identified and accounted for in CMS systems.

In addition, beneficiary addresses are initially provided by SSA from the beneficiary's enrollment in Part A and/ or Part B, and frequently reflect an address of a representative payee or a Post Office (P.O.) Box, not the residence of the beneficiary. This limits the effectiveness of geographically-sensitive Plan payment decisions. Plans have more accurate beneficiary address information, which is updated on a case-by-case basis. Plan supplied residence addresses on an initial Part C and/or Part D enrollment has improved the accurate application of geographically sensitive rates in Plan payment calculation.

5. Small Businesses

Some MA organizations and Part D sponsors are small businesses so they may be affected. They will have to comply with all the information requirements described in this supporting statement.

6. Less Frequent Collection

This collection does not set out any daily, weekly, monthly, or annual requirements; rather this information is collected as needed (upon plan enrollment) to support the administration of the Medicare Part C and Part D plan enrollment process.

7. Special Circumstances

There are no special circumstances that would require this information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

Serving as the 60-day notice, the proposed rule (CMS-4190-P, RIN 0938-AT97) published in the Federal Register on February 18, 2020 [85 FR 9002]. Public comments were due no later than April 6, 2020. No public comments were received on the collection of information for MA Plan Options for End Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110) or the Contracting Standards for Dually-Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514).

The final rule (CMS-4190-F, RIN 0938-AT97) published in the Federal Register on June 2, 2020 [85 FR 33796].

9. Payments/Gifts to Respondents

This enrollment form requests information to determine eligibility for, and enroll a beneficiary into a MA, MA-PD or PDP plan. There are no payments/gifts to respondents. (Requirements for plans offering nominal gifts to beneficiaries for marketing purposes, provided the gift is given regardless of whether they enroll, and without discrimination, are outlined in the *Medicare Communications and Marketing Guidelines*).

10. Confidentiality

The information collected from Medicare beneficiaries and contained in medical records, and other health and enrollment information, is disclosed as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588 (February 14, 2018; 83 FR 6591). Sections 1851 and 1860D-1 of the Social Security Act (the Act) and 42 CFR §§ 422.50, 422.60, 423.30, and 423.32 authorize the collection of this information including all Federal and State laws regarding confidentiality and disclosure.

11. Sensitive Questions

The collection does not solicit questions, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2019 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Salary ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Wage ($/hr)
All Occupations	00-0000	25.72	n/a	n/a
Business operation specialists	13-1000	36.31	36.31	72.62
Office and Administrative Support Workers, All Other	43-9199	18.41	18.41	36.82

Wages for Individuals: To derive average costs for individuals, we used data from the May 2019 National Occupational Employment and Wage Estimates for our salary estimate. We believe that the burden will be addressed under All Occupations (occupation code 00-0000) at $25.72/hr since the group of individual respondents varies widely from working and nonworking

individuals and by respondent age, location, years of employment, and educational attainment, etc.

Unlike our private sector adjustment to the respondent hourly wage, we are not adjusting this figure for fringe benefits and overhead since the individuals' activities would occur outside the scope of their employment.

Information Collection Requirements and Associated Burden Estimates

Subpart B – Eligibility, Election and Enrollment

Eligibility to elect an MA plan (§ 422.50)

Beneficiary Burden

To elect an MA plan an individual must complete and sign an election form or complete another CMS-approved election method offered by the MA organization and provide information required for enrollment.

The burden associated with this requirement is captured below in § 422.60.

Election process (§ 422.60)

The election form or another CMS approved election method offered by the MA organization must be completed by the MA eligible individual (or the individual who will soon become entitled to Medicare benefits) and include authorization for disclosure and exchange of necessary information between CMS and the MA organization. Individuals (i.e. authorized representative) who assist beneficiaries in completing the enrollment form must sign the form and indicate their relationship to the beneficiary.

There are approximately 8,070,726 new enrollments processed by MA and MA-PDs in 2019. For this revised submission, we are adding 59,651 new enrollments to be processed annually for a total of 8,130,377. As explained in section 15 of this supporting statement, this revised estimate consists of the estimated 59,000 beneficiaries to enroll in MA plans and 651 beneficiaries transitioned out of a D-SNP look-alike per year in 2021 through 2023. Based on the information requested for completion by the applicant on the enrollment form, we estimate it takes an enrollee 0.333 hour(s) to complete.

The first burden associated with this requirement is the time and effort necessary for an individual to complete/submit the enrollment request.

The burden for all beneficiaries is estimated as follows:

We estimate an annual burden of 2,707,416 hours (8,130,377 x 0.333 hours), with a consequent burden/cost of $69,634,740 (2,707,416 x $25.72) or $8.56 per beneficiary ($69,634,740/ 8,130,377 new enrollments).

Plan Burden

Additional burden associated with this requirement are 1) the time and effort for the MA plan to determine eligibility for enrollment, 2) submit the enrollment to CMS, 3) generate and submit the enrollment decision to the beneficiary and 4) retain the enrollment request. The time and cost burdens for these actions are outlined below.

(1) We estimate it would take approximately 5 minutes at 72.62/hr for a business operations specialist to determine an enrollee's eligibility and effectuate changes for enrollment. The burden for all organizations is estimated at 672,561 hours (8,070,726 beneficiaries x 5 min/60) at a cost of $48,841,380 (672,561 hours x $72.62/hour) or $90,280 per organization ($48,841,380 /541 MA/MA-PDs).

(2) The MA organization must submit each enrollment transaction to CMS promptly. We estimate it would take the plan 1 minute per enrollment processed. The burden associated with electronic submission of enrollment information to CMS is estimated at 134,512 hours (8,070,726 notices x 1 min/60) at a cost of $9,768,261 (134,512 hr x $72.62/hr business operations specialist) or $1.21 per notice ($9,768,261 / 8,070,726 notices) or $18,056 per organization ($9,768,261 / 541 MA/MA-PD contracts).

(3) Once the enrollment change is completed, CMS estimates it would take 1 minute at $72.62/hr for a business operations specialist to electronically generate and submit a notice to convey acceptance or denial of the enrollment request for each of the 8,070,726 beneficiaries. The burden associated with each organization providing the beneficiary prompt written notice, performed by an automated system, is estimated at 1/60th of an hour (1 minute) per application processed. The annual total burden is estimated at 8,070,726 /60 = 134,512 hours, resulting in an annual cost of 134,512 hours x $72.62 (hourly wage of a business operation specialist) = $9,768,261.

(4) Additionally, per 422.60(c)(2), MA organizations must file and retain MA plan election forms, as well as records of MA enrollment requests made by any other enrollment request mechanism, for the period specified in CMS instructions.

The burden associated with this requirement is the time required for each organization to perform record keeping on each new application filed. It is estimated that it will take each organization 1/12 of an hour (5 minutes) times 8,070,726, the number of new enrollments processed by MA/MA-PDs in 2019, resulting in an annual burden of 8,070,726 x (5 min/60) = 672,561 hours, and an annual cost of 672,561 hours x $36.82 (hourly wage of an administrative and support worker) = $24,763,696.

The total burden to MA and MA-PD plans of 422.60 is 1,614,146 hours (672,561 + 134,512 + 134,512 + 672,561) at a total cost of $93,141,598 (48,841,380 + 9,768,261 + 9,768,261 + 24,763,696).

Subpart B – Eligibility and Enrollment

Enrollment process (§ 423.32)

To elect a Prescription Drug Plan (PDP) an individual must complete and sign an election form or complete another CMS-approved election method offered by the Part D sponsor and provide information required for enrollment.

The election form or another CMS approved election method offered by the stand-alone PDP sponsor must be completed by the Part D eligible individual (or the individual who will soon become entitled to Medicare drug benefits) and include authorization for disclosure and exchange of necessary information between CMS and the PDP sponsor. Individuals (i.e. authorized representative) who assist beneficiaries in completing the enrollment form must sign the form and indicate their relationship to the beneficiary.

There are approximately 6,344,121, new enrollments processed by stand-alone PDPs in 2019. Based on the information requested for completion by the applicant on the enrollment form, we estimate it takes an enrollee 0.333 hour(s) to complete.

The first burden associated with this requirement is the time and effort necessary for an individual to complete/submit the enrollment request.

We estimate an annual burden of 2,112,592 hours (6,344,121x 0.333 hours), with a consequent burden/cost of $54,335,866 (2,112,592 hr x $25.72) or $8.56 per beneficiary ($54,335,866 / 6,344,121 new enrollments).

Plan Burden

Additional burden associated with this requirement are 1) the time and effort for the Part D plan to determine eligibility for enrollment, 2) submit the enrollment to CMS, 3) generate and submit the enrollment decision to the beneficiary and 4) retain the enrollment request. The time and cost burdens for these actions are outlined below.

(1) We estimate it would take approximately 5 minutes at 72.62/hr for a business operations specialist to determine an enrollee's eligibility and effectuate changes for enrollment. The burden for all organizations is estimated at 528,677 hours (6,344,121 beneficiaries x 5 min/60) at a cost of $38,392,524 (528,677 hours x $72.62/hr) or $639,875 per organization ($38,392,524/60 PDPs).

(2) As noted in 423.32 (c), the Part D sponsor must submit each enrollment transaction to CMS promptly. We estimate it would take the plan 1 minute per enrollment processed. The burden associated with electronic submission of enrollment information to CMS is estimated at 105,735 hours (6,344,121 notices x 1 min/60) at a cost of $7,678,476 (105,735 hr x $72.62/hr business operations specialist) or $1.21 per notice ($7,678,476 / 6,344,121 notices) or $127,975 per organization ($7,678,476 / 60 Part D contracts).

(3) Once the enrollment change is completed, CMS estimates it would take 1 minute at $72.62/hr for a business operations specialist to electronically generate and submit a notice to convey acceptance or denial of the enrollment request for each of the 6,344,121 beneficiaries. The burden associated with each sponsor providing the beneficiary prompt written notice, performed by an automated system, is estimated at 1/60th of an hour (1 minute) per application processed. The annual total burden is estimated at 6,344,121/60 = 105,735 hours, resulting in an annual cost of 105,735 hours x $72.62 (hourly wage of a business operation specialist) = $7,678,476.

(4) Additionally, PDP sponsors must file and retain Part D plan election forms, as well as records of PDP enrollment requests made by any other enrollment request mechanism, for the period specified in CMS instructions.

The burden associated with this requirement is the time required for each organization to perform record keeping on each new application filed. It is estimated that it will take each organization 1/12 of an hour (5 minutes) times 6,344,121, the number of new enrollments processed by standalone PDPs in 2019, resulting in an annual burden of 6,344,121 x (5 min/60) = 528,677 hours, and an annual cost of 528,677 hours x $36.82 (hourly wage of an administrative and support worker) = $19,465,887.

The total burden to stand-alone Part D plan sponsors of 432.32 is 1,268,824 hours (528,677 + 105,735 + 105,735 + 528,677) at a total cost of $73,215,363 (38,392,524 + 7,678,476 + 7,678,476 + 19,465,887).

As established by 42 CFR 422.50 and 422.60, individuals who meet the eligibility criteria may enroll in an MA plan. Similarly, 42 CFR 423.30 and 423.32 affords individuals eligible for Part D to enroll in a PDP. Requests for enrollment must comply with CMS instructions and be approved by CMS. CMS permits multiple ways in which a beneficiary can submit an enrollment request to the MA or Part D organization of his or her choice, such as paper, telephonic and electronic. In all instances, the MA and Part D organization is required to determine eligibility for enrollment based on the required collection of information.

While each organization develops their own enrollment collection (or “form”), sub-regulatory guidance, Chapter 2 and Chapter 3 of the Medicare Managed Care Manual outlines the items required to be collected for each enrollment request. These items are required to determine if the beneficiary is eligible for plan enrollment per statutory and regulatory requirements, and to submit the enrollment transaction to CMS. The enrollment request may also include optional items, which aid the MA and Part D organization to efficiently process the request and set up beneficiary preferences for services.

Previously, the model enrollment form was not an OMB-approved form; however, the data elements required to be collected in order for the enrollment request to be considered valid were approved under OMB control number 0938-0753 (CMS-R-267) and 0938-0964 (CMS-10141). The new model enrollment “form” (attachment 1a), pending OMB approval, limits data collection to what is lawfully required 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 is arranged in three parts. It includes: (1) cover page with instructions, (2) enrollment form, and, (3) optional sponsor addendum which is not required to be completed by the beneficiary. This optional addendum can include items such as premium payment option or beneficiary's choice of primary care physician including beneficiary language or accessible format preference. Please see model enrollment form attached.

Subpart V – Medicare Advantage Communication Requirements

Review and Distribution of Marketing Materials (§ 422.2262)

To customize and produce the enrollment forms will require two teams: one team for requirements and another team for implementation.

The team to produce requirements will consist of a chief executive, a marketing manager, a web developer and a compliance officer. The chief executive is needed to explain plan goals. The marketing manager is needed to explain what sells best. Similarly, the web developer is needed to explain how people use websites and what works well. Finally, the compliance officer will assure that all needed elements are present. This requirements team will have an hourly wage of $479.12 as shown in Table 2.

Table 2: Implementation Team & Requirements				
Occupation Title	Occupation Code	Mean Salary	Fringe Benefits and Overhead	Cost per hour
Chief Executives	11-1011	93.20	93.20	186.40
Marketing Managers	11-2021	71.73	71.73	143.46
Web Developers	15-1257	39.60	39.60	79.20
Compliance Officers	13-1041	35.03	35.03	70.06
Computer Programmer	15-1251	44.53	44.53	89.06
Computer Systems analyst	15-1211	46.23	46.23	92.46

We estimate that each of the 541 MA/MA-PD contracts will spend four hours for the development at a per contract cost of $1,916.48 (4*479.12). Therefore, the 541 plans will spend 2,164 hours (541*4 hr) at a cost of 1,036,816 (1,916.48*541).

1 Requests for enrollment must comply with all requirements outlined in §422.2262 & 423.2262 and be approved by CMS.

To implement the requirements will require a team of two professionals, a computer programmer and a computer systems analyst. The systems analyst is needed because multiple systems are being used both enrollment systems and web systems and the software programmer is needed to write the code. The hourly wage for the implementation team is $181.52. This is presented in Table 2

We estimate that each of the 541 contracts will spend 2 hours for the software implementation at a cost of $363.04 (2*181.52). Therefore, all 541 contracts will spend a total of 1082 hours (541 contract * 2 hours) at a cost of $196,405 (541*363.04/contract).

The total burden for 541 contracts is 3,606 hours (2,164 hours requirements + 1082 hours for implementation) at an aggregate cost of 1,233,221 (1,036,816 for requirements + $196,405 for implementation).

Subpart V – Communication Requirements, Review and Distribution of Marketing Materials (§ 423.2262)

To customize and produce the enrollment forms will require two teams: one team for requirements and another team for implementation.

The team to produce requirements will consist of a chief executive, a marketing manager, a web developer and a compliance officer. The chief executive is needed to explain plan goals. The marketing manager is needed to explain what sells best. Similarly, the web developer is needed to explain how people use websites and what works well. Finally, the compliance officer will assure that all needed elements are present. This requirements team will have an hourly wage of $479.12 as shown in Table 2.

We estimate that each of the 60 PDP contracts will spend four hours for the development at a per contract cost of $1,916.48 (4*479.12). Therefore, the 60 plans will spend 240 hours (60*4 hr) at a cost of 114,989 (1,916.48*60).

To implement the requirements will require a team of two professionals, a computer programmer and a computer systems analyst. The systems analyst is needed because multiple systems are being used both enrollment systems and web systems and the software programmer is needed to write the code. The hourly wage for the implementation team is $181.52. This is presented in Table 2.

We estimate that each of the 60 PDP contracts will spend 2 hours for the software implementation at a cost of $363.04 (2*181.52). Therefore, all 60 PDP contracts will spend a total of 120 hours (60 contract * 2 hours) at a cost of $21,782 (60*363.04/contract).

The total burden for 60 contracts is 360 hours (240 hours requirements + 120 hours for implementation) at an aggregate cost of 136,771 (114,989 for requirements + $21,782 for implementation).

13. Capital Costs

Potential implementation costs are discussed in Section 12 which includes the costs of producing software. No additional capital or IT equipment costs will result from this collection since the software upgrades are sufficient to accomplish the task. MA and Part D Sponsors IT systems are fully operational/equipped to accept plan enrollments and determine an individual's eligibility per statutory and regulatory requirements.

14. Cost to Federal Government

MA organizations and Part D sponsors are responsible for the information collection requirements in this package. Plans receive the enrollment, determine eligibility, make a determination if the enrollment is accepted, denied or incomplete and finally communicate the decision to the beneficiary within specified timeframes. CMS systems provide automated responses to plan submitted transactions on a transaction reply report, which includes no additional burden or cost to change or shorten the enrollment form. There is no change to the process CMS uses for plans to submit the enrollment and therefore there is no additional cost to the Federal Government.

15. Program/Burden Changes

The current collection of information as required by 42 CFR 422.50, 422.60, and 423.32 was originally approved under OMB Control No. 0938-1378 (CMS-10718) on July 17, 2020. It incorporated changes to the previous standard ("long") model enrollment form (used by both MA and PDP sponsors) which yielded a new "shortened" model enrollment form. As outlined in Section 12 and 15 of this Supporting Statement, we are updating this collection of information request to account for changes to the number of Medicare-eligible beneficiaries estimated to make a valid enrollment request for calendar year (CY) 2021 through 2023 as set out in CMS-4190-F [85 FR 33796] to include the MA Plan Options for End Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110) and the Contracting Standards for Dually-Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514). This updated information collection request does not propose any program changes or adjustments.

We are not proposing changes to any of our currently approved forms nor are we adding or removing any such forms.

ICRs Regarding Medicare Advantage (MA) Plan Options for End-Stage Renal Disease (ESRD) Beneficiaries (§§ 422.50, 422.52, and 422.110)

As described in CMS-4190-F, the 21st Century Cures Act (Pub. L. 114-255) amended sections 1851, 1852, and 1853 of the Act to expand enrollment options for individuals with ESRD. Specifically, since the beginning of the MA program, individuals with ESRD have not been able to enroll in MA plans subject to limited exceptions. Section 17006(a) of the Cures Act removed this prohibition effective for plan years beginning on or after January 1, 2021. We codified this change in CMS 4190-F1 (85 FR 33901) with revisions to §§ 422.50(a)(2), 422.52, and 422.110,

to allow ESRD beneficiaries, without any limitation not otherwise applicable for enrollment in the MA program, to enroll in an MA plan.

Enrollment processing and notification requirements codified at § 422.60, are not being revised as part of this rulemaking, and no new or additional information collection requirements are being imposed. Additionally, as explained in CMS-4190-F, CMS' Office of the Actuary (OACT) had already incorporated an increase in ESRD enrollment in the Medicare Trust Fund baseline due to the legislation. Therefore, there is no need to estimate plan burden. However, the burden for an enrollee to complete an enrollment form has not been incorporated into the OACT baseline and therefore is estimated in this section.

Beginning with the 2020 Annual Election Period (AEP), for a January 1, 2021 effective date, ESRD beneficiaries will be completing the enrollment form attached to this information collection request or complete another CMS-approved election method offered by the MA plan, or will call 1-800-MEDICARE, and provide information required for enrollment. Regardless of the enrollment mechanism, similar identifying information is collected by the MA plan to process the enrollment.

We estimate an average increase of 59,000 ESRD beneficiaries to enroll in MA plans per year in 2021 through 2023. On average we estimate an annual burden of 19,647 hours (59,000 new ESRD enrollees x 0.333 hr per enrollment) at a cost of $505,321 (19,647 hr x $ 25.72/hr).

Please note that the Collection of information section of the CMS-4190-F rule has mistakenly set out a per response time of 0.3333 hours which equated to a burden of 19,665 hours (59,000 responses x 0.3333 hr/response). Consistent with our current per response time estimate, the response time should have been 0.333 hours equating to a burden of 19,647 hours (59,000 responses x 0.3333 hr/response). This is a difference of -18 hours.

Burden Category	Total Annual Respondents	Response Frequency (per year)	Total Annual Response s	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
MA Plan Options for ESRD Beneficiaries (§§ 422.50, 422.52, and 422.110)	59,000	1	59,000	0.333	19,647	25.72	505,321

ICRs Regarding Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)

As described in CMS-4190-F, we established new contract requirements that are necessary to fully implement federal D-SNP requirements, especially those related to Medicare-Medicaid integration codified at §§ 422.2, 422.107, and 422.629 through 422.634 pursuant to the Bipartisan Budget Act of 2018. We finalized a prohibition on CMS entering into a new contract for plan year 2022 and future years for any non-SNP MA plan that projects in its bid submitted under § 422.254, that 80 percent or more of the plan's total enrollment are enrollees entitled to

medical assistance under a state plan under Title XIX of the Act. Additionally, we finalized a prohibition for plan year 2023 and future years on CMS renewing an existing contract for any non-SNP MA plan that an MA organization offers that has actual enrollment, as determined by CMS in January of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under title XIX of the Act, unless the MA plan has been active for less than 1 year and has enrollment of 200 or fewer individuals at the time of such determination.

The MA organization with a D-SNP look-alike plan has the opportunity to make an informed business decision to transition enrollees into another MA-PD plan (offered by it or by its parent organization). We expect the vast majority of D-SNP look-alike enrollees will be transitioned into a plan offered by the same parent organization as the D-SNP look-alike, and we expect in rare instances that the non-renewing plan may choose to not transition enrollees. Using data from the most recently available contract year, the 2020 bid submission process, we estimate that there are 62 MA plans that will be subject to § 422.514(d) with a total enrollment of 180,758 for contract year 2020.

Section 422.514(e)(2) allows any individual transitioned from a D-SNP look-alike to another MA-PD plan to stay in the MA-PD plan receiving the enrollment or make a different election. The enrollees may choose new forms of coverage for the following plan year, including a new MA-PD plan or receiving services through the original Medicare fee-for-service program option and enrollment in a stand-alone Prescription Drug Plan (PDP). Because the enrollment transition process will be effective on January 1 and notices would be provided during the AEP, affected individuals have opportunities to make different plan selections through the AEP (prior to January 1) or the Medicare Advantage Open Enrollment Period (after January 1). Affected individuals may also qualify for a Special Election Period (SEP), such as the SEP for plan non-renewals at § 422.62(b)(1) or the SEP for dually eligible/LIS beneficiaries at § 423.38(c)(4).

Based on our experience with passive enrollment of dually eligible beneficiaries into a new plan under the same parent organization for MMPs in the Financial Alignment Initiative, we estimate that one percent of the 180,758 transitioning D-SNP look-alike enrollees will select a new plan or the original Medicare fee-for-service program and PDP option rather than accepting the transition into a different MA-PD plan or D-SNP under the same MA organization as the D-SNP look-alike in which they are currently enrolled. We estimate that 1 percent or 1,808 enrollees (180,758 transitioning D-SNP look-alike enrollees * 0.01), will opt out of the new plan into which the D-SNP look-alike transitioned them. The enrollment process requires 20 minutes (0.3333 hours) and remains unchanged. The total added burden for enrollees will be 603 hours (1,808 enrollees x 0.333 hr/response) at a cost of $15,509 (603 hr x $25.72/hr). We are averaging this burden over the 2021 and 2022 plan years, resulting in an annual burden of 302 hours (603 hr/2 yr) at a cost of $7,755 ($15,509/2 yr).

We believe that in subsequent years (2023 and beyond), at most five plans will be identified as D-SNP look-alikes and therefore this final regulation would have a much smaller impact on MA enrollees after the initial period of implementation. Since the current 62 D-SNP look-alike plans have 180,758 enrollees in 62 plans, we estimate 14,577 enrollees (180,758 enrollees x 5/62 plans) in 5 plans. Therefore, the maximum number of enrollees affected per year is estimated to be 146 enrollees (14,577 total enrollees estimated in five plans x 0.01 who would select another

plan). This would amount to a maximum annual burden of 49 hours (146 enrollees x 0.3333 hr) at a cost of $1,260 (49 hr x $25.72/hr).

The average annual enrollee burden over OMB's typical three year approval period is 218 hours ([302 hr for year 1 +302 hr for year 2 + 49 hr for year 3]/3 yr) at a cost of $5,590 ([$7,755 for year 1+ $7,755 for year 2 + $1,260 for year 3]/3yr).

Burden Category	Total Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Contracting Standards for D-SNP Look-Alikes (§ 422.514)	1,954enrollees (904 for year 1 + 904 for year 2 + 146 for year 3)	1	651 (1,954 responses/3 yr)	0.333	218	25.72	5,590

Proposed Changes (Total)

Burden Category	Total Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
MA Plan Options for ESRD Beneficiaries (§§ 422.50, 422.52, and 422.110)	59,000	1	59,000	0.333	19,647	25.72	505,321
Contracting Standards for D-SNP Look-Alikes (§ 422.514)	651	1	651	0.333	218	25.72	5,590
TOTAL	+59,651	1	+59,651	0.333	+19,865	25.72	+510,911

	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Currently Approved	23,551,767	1	23,551,767	0.333	7,687,080	25.72	69,123,837

	Total Annual Respondents	Response Frequency (per year)	Total Annual Responses	Time Per Response (hr)	Total Annual Time (hr)	Labor Cost ($/hr)	Total Annual Cost ($)
Burden							
Proposed Burden	23,611,418	1	23,611,418	0.333	7,706,944	25.72	69,634,740
Reconciliation (see preceding table, "Proposed Changes (Total)"	+ 59,651	No Change	+ 59,651	No Change	+19.864	No Change	+510,903

The 1 hour time difference (19,865 hr vs 19,864 hr) can be attributed to rounding.

16. Publication/Tabulation

There are no plans to publish or tabulate the information collected.

17. Expiration Date

CMS would like the MA and Part D enrollment forms to display the expiration date next to the OMB control number.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

This collection does not employ statistical methods.