

January 26, 2026

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Submitted electronically to: <https://www.regulations.gov>

**Re: Medicare and Medicaid Programs; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program; 90 Fed Reg 54894 (Nov. 28, 2025) CMS-4212-P**

The Center for Medicare Advocacy (CMA) is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality health care. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with longer-term conditions. CMA's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues annually. Additionally, CMA provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit these comments to the above-referenced proposed rule.

#### **IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes) (p. 54941)**

##### *Special Enrollment Period for Provider Terminations (§422.62(b)(23))*

CMS proposes to broaden the current Special Enrollment Period (SEP) available for certain Medicare Advantage provider network terminations. The agency states: "Specifically, at § 422.62(b)(23) we propose to change the eligibility criteria for the current SEP for Significant Change in Provider Network to reflect that a determination of significant provider network change by CMS or an MA organization is not necessary for an enrollee who is affected by the provider network change to be eligible for the SEP" (p. 54942). CMS proposes that an "affected enrollee" would be defined "an enrollee who is assigned to, currently receiving care from, or has received care within the past 3 months from a provider or facility being terminated" (p. 54942).

**We strongly support this proposal which fosters continuity of care by allowing MA enrollees to change plans in order to maintain their access to their current provider.** We also support CMS' statement that this SEP right will be accompanied by a guaranteed issue (GI) right to purchase Medigap plans should the affected individual choose to return to traditional Medicare.

*Coordination of Election Mechanisms for MA and Part D (§§ 422.62, 422.66, 423.32, 423.36, and 423.38) (p. 54942)*

CMS proposes “to codify our current policy that for elections that are made based on certain special election periods, the beneficiary at issue must either have CMS approval for the use of that SEP through the use of a CMS-operated election mechanism (for example, 1–800–MEDICARE or the Online Enrollment Center (OEC)) or other means, such as enrollee receipt of a notice” (p. 54943). While we understand the need for CMS approval of an SEP, a beneficiary should not be required to provide receipt of notice – CMS can confirm eligibility for an SEP for a given individual without the requirement that they provide documentation.

Further, CMS makes reference to the involvement of an agent or broker assisting an enrollee, including noting that “[t]he enrollee can meet with an agent/broker for assistance in selecting the best plan for the enrollee” (p. 54944/51). Curiously absent from this discussion is assistance from State Health Insurance Assistance Programs (SHIPs) which, unlike an agent/broker, does not have a pecuniary interest in the individual’s plan selection. CMS should promote the availability of SHIPs whenever possible, including when beneficiaries need assistance with exercising their SEP rights.

*Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements (§§ 422.2267 and 423.2267) (p. 54950)*

CMS proposes that Third-Party Marketing Organizations (TPMOs) no longer need to reference State Health Insurance Assistance Programs (SHIPs) as a source of information on all plan options. **We strongly object to this proposal and view it as an effort by CMS to sideline SHIPs while both promoting agents and brokers and limiting their oversight. For the reasons outlined below, we urge CMS to rescind this proposal.**

We remind CMS of its own justification for instituting these disclaimers as outlined in the proposed 2023 rule (CMS-4192-P), as discussed in our comments to that rule.<sup>1</sup> In the preamble to the proposed 2023 rule, CMS noted that it “has seen an increase in beneficiary complaints associated with and has received feedback from beneficiary advocates and stakeholders concerned about the marketing practices of third-party marketing organizations (TPMOs) who sell multiple MA and Part D products. In 2020, we received a total of 15,497 complaints related to marketing. In 2021, excluding December, the total was 39,617” (CMS-4192-P, pp. 1844-5).

During reviews of sales and enrollment call recordings between TPMO staff and beneficiaries, CMS reported that “[m]any of these calls demonstrate that beneficiaries are confused by these TPMOs, including confusion regarding who they are speaking to, what plans the TPMOs represent, and that the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations” (CMS-4192-P, pp. 1900-01).

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<sup>1</sup> CMA comments to proposed CY2023 rule, available here: <https://medicareadvocacy.org/cma-comments-on-2023-part-c-and-part-d-payment-policies/>.

As we noted at the time, CMS' findings were (and continue to be) consistent with the CMA's experience, along with that of SHIP and Senior Medicare Patrol (SMP) programs with whom we communicate. Similarly, in comments to the 2023 propose rule, the National Association of Insurance Commissioners (NAIC) reported<sup>2</sup> that it and state regulators had heard many stories in which beneficiaries have enrolled in or been enrolled in plans with narrow networks that didn't include their current providers, had pharmacy benefits with higher costs, imposed higher copayments than expected, didn't have the benefits they had seen advertised, or that were completely inappropriate for their particular needs and not what they thought they were buying. These sales often involved agents/brokerages or TPMOs that represent only some of the options available to Medicare beneficiaries.

In our comments to the proposed 2023 rule, we asserted that the rules should be even stronger, including a reference to SHIPs; as we noted, "CMS funds these programs and they are the obvious Medicare experts in each state, and are a trusted resource for beneficiaries to get personalized assistance and verify the information they are receiving from third party marketers, brokers or agents."

In addressing the revised disclaimer adding SHIPs as a source of information required by the April 2023 Final Rule, CMS notes in the current proposed rule that in comments to the prior proposed rule, "some stakeholders pointed out that budget constraints and limited training would hinder a SHIP's ability to effectively assist beneficiaries with plan choices" (p. 54950). CMS now seems to adopt this stance of commenters, undoubtedly largely made up of agents and brokers who view SHIPs as competition. At the same time, CMS makes no reference to comments submitted by consumer advocates and others who strongly supported this change.

CMS notes that "[b]ased on CMS's review and industry feedback, CMS determined that additional changes to the TPMO disclaimer may be appropriate" including reading the disclaimer "prior to the discussion of any benefits" instead of within the first minute and "remove SHIPs as a source of information from the disclaimer" (p. 54950).

CMS articulates its rationale for removing referral to SHIPs:

CMS is also proposing to remove SHIPs as a source of information from the disclaimer. CMS recognizes that, while SHIPs can be a source of unbiased information about plan choices, informing beneficiaries on every sales call about the SHIP may cause additional issues. SHIP volunteers may not always have the expertise to help beneficiaries navigate increasingly complex MA and Part D programs. CMS believes that beneficiaries enrolled in the MA and Part D programs may be more effectively served by information and entities for which CMS has direct oversight. Moreover, a recent article in the Journal of the American Medical Association Network [citation omitted] details a study conducted to determine if SHIP counselors provided accurate and complete information to Medicare beneficiaries about their coverage options. In this study, mystery shoppers posed as

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<sup>2</sup> National Association of Insurance Commissioners (NAIC) letter to CMS (March 4, 2022), available at Senior Issues (B) Task Force (SITF) webpage under the Documents tab at:[https://content.naic.org/cmt\\_e\\_b\\_senior\\_issues.htm](https://content.naic.org/cmt_e_b_senior_issues.htm).

individuals newly eligible for Medicare. While over 94 percent of the responses differentiating Original Medicare from MA were accurate, fewer than half of counselors mentioned Dual-Eligible Special Needs Plans (D-SNPs) as an option for mystery shoppers posing as dually eligible beneficiaries. The results suggested that SHIPs may not always be able to address the needs of Medicare beneficiaries seeking unbiased information on coverage options

CMS also recognizes that each SHIP works differently and provides different training to its counselors, which can vary further at the local level. This can result in Medicare beneficiaries receiving different information based on the SHIP and SHIP counselor that is ultimately reached. CMS believes that, for the TPMO disclaimer, 1-800-MEDICARE is a better option to assist beneficiaries with health care choices. 1-800-MEDICARE has representatives available 24/7 to assist beneficiaries, provides standardized training to its customer service representatives, is centrally monitored and controlled by CMS, which facilitates efficient and consistent information sharing, and is a one-stop shop for all beneficiaries, regardless of the state in which they live. (p. 54951)

CMS' articulated rationale completely ignores a number of relevant issues, including, as discussed further below: 1) ongoing marketing misconduct and financial incentives of agents and brokers, including the fact that TPMOs don't have to sell all available plans in a given area; and 2) the value of SHIPs and their unbiased counseling compared to both agents/brokers and the shortcomings of 1-800-MEDICARE.

Misconduct surrounding the sale of MA and Part D plans continues apace. As we outlined in a 2025 issue brief:<sup>3</sup>

As a result of aggressive marketing campaigns, as well as the overwhelming number of plan options available, in 2022 about one in three beneficiaries used insurance agents or brokers to help them choose a plan. Agents contract with insurers to enroll beneficiaries into those companies' plans. Agent compensation and bonuses (such as trips, parties and cash) has historically been tied to enrolling large numbers of beneficiaries into specific plans. This incentive model creates a situation where an agent's own financial interest might be at odds with the health care needs of the beneficiary he or she is advising. Insurers also make payments to companies known as field marketing organizations (FMOs) that provide administrative and operational support to agents and brokers, such as marketing and technology infrastructure [citations omitted].

In our brief, we cited to a November 2022 Senate Finance Committee report<sup>4</sup> which found:

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<sup>3</sup> Center for Medicare Advocacy, Issue Brief: "Marketing Medicare Advantage and Part D Plans: Regulation and Recent Legal Challenges" (March 27, 2025), available at: <https://medicareadvocacy.org/wp-content/uploads/2025/03/2025-CMA-Issue-Brief-Marketing-MA-and-Part-D-Plans.pdf>.

<sup>4</sup> U.S. Senate Committee on Finance, Majority Staff, "Deceptive Marketing Practices Flourish in Medicare Advantage" (Nov. 2022) available at: <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

that some TPMOs, brokers, and agents are cold calling seniors, enrolling seniors and people living with disabilities in plans without their consent, and enrolling seniors in plans that don't meet their needs. Most troubling, it appears that vulnerable individuals with cognitive impairments and dual eligibility are being targeted.

More recently in March 2025, Senator Ron Wyden, Ranking Member of the Senate Finance Committee, released a report titled “Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen”<sup>5</sup> which found rapid growth in spending on marketing, and, as noted in the sub-heading to the corresponding press release, “Third-Party Marketing Organizations Resort to Increasingly Predatory Tactics to Enroll Seniors in Preferred Private Medicare Plans that Don't Meet Their Needs”.<sup>6</sup> As summarized in the press release, key findings of the report include:

- Spending on “agents and brokers fees and commissions” by insurance companies investigated by the committee increased \$2.4 billion to \$6.9 billion from 2018 to 2023, nearly tripling.
- State and federal regulators have limited oversight of marketing practices, especially with the increased use of TPMOs and other subcontractors.
- The Medicare Advantage marketing boom has encouraged insurance companies and brokers to aggressively enroll seniors into plans that may not cover their preferred doctor or cover key health benefits.

Recognizing challenges that beneficiaries face in the Medicare marketplace, the Senate report concludes:

Medicare enrollees face a confusing and overly complex landscape of health plan options. While Traditional Medicare does not meaningfully market its services, MA plans flood the zone with mailers, online advertisements, and phone calls. These marketing services are conducted by a vast array of plan marketing affiliates, all for the purpose of directing eligible beneficiaries toward a private plan. They are sometimes deceptive and sometimes unclear. By the time a beneficiary speaks with an insurance agent, they may have been steered on the basis of minimal information about their health needs and are dramatically more likely to make an enrollment decision on the basis of their conversation with a broker. A resulting plan enrollment may not meet their health needs, may constrain choice of health care provider, and might impose the added burden of prior authorization and referral requirements.

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<sup>5</sup> Senate Finance Committee Ranking Member Ron Wyden, “Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen” (March 2025), available at: [https://www.finance.senate.gov/download/pushing-medicare-advantage-on-seniors-unraveling-the-complex-network-of-marketing-middlemen\\_-32425docx](https://www.finance.senate.gov/download/pushing-medicare-advantage-on-seniors-unraveling-the-complex-network-of-marketing-middlemen_-32425docx).

<sup>6</sup> Sen. Wyden press release titled “Wyden Investigation Finds Rapid Growth in Spending on Marketing Middlemen Among Medicare Advantage Plans” (March 25, 2025), available at: <https://www.finance.senate.gov/ranking-members-news/wyden-investigation-finds-rapid-growth-in-spending-on-marketing-middlemen-among-medicare-advantage-plans>.

Agents and brokers, along with TPMOs, do not have to contract with or sell all available plans in a given service area. This alone negatively impacts fully informed decision-making on the part of Medicare beneficiaries. Further, higher commissions are generally paid for Medicare Advantage (MA) plans compared to stand-alone Part D plans and Medigaps. Even within the MA market, insurers try to drive – or suppress – enrollment based on differing commissions between plan offerings.

For instance, in the most recent open enrollment period in the Fall of 2025, MA plans seeking to limit enrollment in certain less profitable plans cut back on commissions to brokers and other third-party marketers, while increasing commissions for more profitable plans. As noted in a recent *STAT* article:<sup>7</sup>

The most recent actions from Medicare insurers are catching the ire of state insurance officials, who are worried Medicare beneficiaries are having their choices artificially suppressed. [...] Cutting or eliminating commissions paid to brokers is a sign that insurance companies don't want any more enrollment — usually because they are enrolling too many people and are worried medical costs will rise. Although brokers may have a responsibility to enroll people in the best coverage for them, they have no incentive to enroll people in plans that don't pay.

As noted in a recent *Think Advisor* article,<sup>8</sup> insurers have deliberately tried to influence enrollment choices in different plans by manipulating commissions:

Once the issuers saw more 2025 claims, and they decided that they had put underpriced products on the shelves for 2026, they took steps such as eliminating sales commissions and pulling plans off of electronic sales systems to keep hordes of potentially costly enrollees from surging onto their customer lists.

Further, many insurers pay no commission for Part D enrollments – severely disincentivizing agents and brokers from discussing stand alone Part D plans, and in turn, the option of traditional Medicare, instead favoring higher commissions for select MA plans. As stated in the same *STAT* article referenced above:

Brokers told STAT that the marketplace for Medicare prescription drug plans, known as Part D, has become particularly untenable. Almost none of the insurers selling Part D plans are paying commissions — meaning brokers are working for free if they help someone sign up for a Part D plan.

By proposing to eliminate reference to SHIPs in the TPMO disclaimer, CMS undermines the value of SHIPs and their unbiased counseling. In order to justify this proposal, CMS makes

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<sup>7</sup>*STAT News* “Major health insurers like Humana, UnitedHealth are cutting broker commissions to avoid costly Medicare enrollees” by Bob Herman (Nov. 25, 2025), available at: <https://www.statnews.com/2025/11/25/health-insurers-avoid-costly-new-medicare-enrollees-regulators-say/>.

<sup>8</sup> *Think Advisor*, “Many Insurers Hid From 2026 Medicare Advantage Plan Sales” by Allison Bell (Dec. 8, 2025), available at: <https://www.thinkadvisor.com/2025/12/08/many-insurers-hid-from-2026-medicare-advantage-plan-sales/>.

reference to a *JAMA* article<sup>9</sup>, and while conceding that “over 94 percent of the responses differentiating Original Medicare from MA were accurate” points to the finding that “fewer than half of counselors mentioned Dual-Eligible Special Needs Plans (D-SNPs) as an option for mystery shoppers posing as dually eligible beneficiaries” and therefore concludes that “[t]he results suggested that SHIPs may not always be able to address the needs of Medicare beneficiaries seeking unbiased information on coverage options.” As discussed above, SHIPs are the only source of unbiased information compared to agents and brokers heavily influenced by disparate commissions driving enrollment that might not be the best options for individuals. As noted in the same *JAMA* article, “Insurance brokers can provide helpful information but may have financial incentives to steer enrollees to suboptimal choices.” Further, CMS ignored one of the *JAMA* article’s conclusions: “Given recent growth in MA and federal efforts to counter deceptive marketing practices from agents or brokers—in part by directing beneficiaries to SHIPs—policymakers should consider providing SHIP with additional resources for training and capacity improvements.”

Had CMS chosen to highlight the importance of SHIPs, rather than diminish their role in the Medicare marketplace, the agency could have consulted and cited to other sources, including with respect to the value the program offers in comparison to TPMOs, agents and brokers. Instead, CMS asserts that “for the TPMO disclaimer, 1-800-MEDICARE is a better option to assist beneficiaries with health care choices.”

Both 1-800-MEDICARE and private actors selling Medicare coverage fall short of the level and type of assistance to beneficiaries provided by SHIPs. As noted in a KFF report, the Medicare landscape facing consumers is daunting.<sup>10</sup>

Recent years have also seen a steep rise in advertising for private Medicare plans, as well as aggressive marketing tactics by insurance brokers and other third-party marketing groups, which may make it increasingly difficult for beneficiaries to seek clear guidance and select the coverage that best meets their needs.

The KFF report compares assistance provided by SHIPs compared to agents and brokers, and reiterates the justification for including reference to SHIPs in TPMO disclaimers:

Nonetheless, while many beneficiaries find brokers to be a helpful resource, they generally do not offer the same level of unbiased counseling as financially disinterested resources such as SHIPs or 1-800-MEDICARE, as they may not represent all coverage options available in a given county or region, and often have a financial incentive to steer beneficiaries towards Medicare Advantage over other forms of coverage. Following a rise in beneficiary complaints about misleading marketing practices by brokers and other third-party marketing groups, the Centers for Medicare & Medicaid Services (CMS)

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<sup>9</sup> *JAMA*, “Accuracy of Medicare Information Provided by State Health Insurance Assistance Programs” by Kacey Dugan, Ilse Peterson, Allison Dorneo and Melissa Garrido (April 1, 2025), available at: [https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2832052#google\\_vignette](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2832052#google_vignette).

<sup>10</sup> KFF, “The Role of SHIPs in Helping People with Medicare Navigate Their Coverage” (Sept 2025), available at: <https://www.kff.org/medicare/the-role-of-ships-in-helping-people-with-medicare-navigate-their-coverage/>.

began requiring third-party marketing materials to mention SHIPs as an additional resource in 2024, highlighting the unique service that SHIPs provide in Medicare’s increasingly complex coverage environment.

Comparing the level of assistance SHIPs vs. 1-800-MEDICARE can provide, the report notes:

In comparison to 1-800-MEDICARE, the federal helpline for information and assistance with Medicare health coverage issues, SHIPs cover counseling topics in greater depth and offer more personalized assistance. For this reason, SHIPs often take referrals from 1-800-MEDICARE and other federal aging and disability resources to address more complex beneficiary concerns.

Noting that SHIP counselors spent on average three times the number of minutes spent on each counseling session compared to 1-800-MEDICARE contacts, the report notes that “[g]iven the more extensive one-on-one support provided by SHIP counselors, CMS often coordinates with local SHIP offices to refer beneficiaries whose cases are too complex to be addressed during calls to 1-800-MEDICARE alone.”

Among the resources KFF cites to is a 2024 document issued by the Department of Health & Human Services’ own Administration for Community Living (ACL),<sup>11</sup> which describes the critical role that SHIPs play:

Accessing affordable health insurance can be difficult even for those with Medicare. The SHIP program is the only resource that provides this level of unbiased, in-depth counseling and one-on-one assistance to older adults and people with disabilities who struggle to navigate the complexities of their financial and medical needs. Many beneficiaries utilize SHIP every year because of the complexity of their situations, including prescription needs and identifying plan network. SHIP counseling can help Medicare beneficiaries save thousands of dollars per year.

Helping illustrate the complexity of the assistance provided to SHIP beneficiaries, the average time spent on one-on-one counseling continues to increase annually, reflecting the ongoing need for and complexities of the questions and help that Medicare beneficiaries request. The average length of time spent assisting beneficiaries increased from 28 minutes in 2014 to 33 minutes in 2020. This is more than three times the 9.5-minute call average to the 1-800 Medicare call center reflecting the greater complexity of issues handled by SHIPs in comparison to 1-800 Medicare.

As summarized in a 2025 post by Georgetown University’s Medicare Policy Initiative:<sup>12</sup>

The value of SHIP is especially obvious when individuals eligible for Medicare are trying to decide among traditional Medicare, Medigap plans, MA plans, and Medicare Part D

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<sup>11</sup> “DHHS FY 2025 Administration for Community Living, Justification of Estimates for Appropriations Committees” (2024) available at: <https://acl.gov/sites/default/files/about-acl/2024-03/FY2025ACL-CJ-508.docx>.

<sup>12</sup> Medicare Policy Initiative, “SHIPs Provide a Critical Service for Medicare Beneficiaries” By Jack Hoadley, Beth Fuchs, and Rachel Schmidt (May 14, 2025), available at: <https://medicare.chir.georgetown.edu/ships-provide-a-critical-service-for-medicare-beneficiaries-may-14-2025/>.

drug plans. SHIP counselors are vital resources, especially in an environment saturated with aggressive insurance company marketing and insurance brokers who may be giving advice in line with their personal financial motivations rather than a beneficiary's best interests.

The Center for Medicare Advocacy strongly supports the current TPMO disclaimer informing beneficiaries, when applicable, that the TPMO does not contract with every available plan in a given service area. We also strongly support the current requirement that beneficiaries interacting with the TPMO be advised of the availability of SHIP services, where Medicare beneficiaries can get unbiased information about all available options in a given area, including all MA plans, all Part D plans and all Medigap plans, along with information about Medicare Savings Programs (MSPs), the Part D Low-Income Subsidy (LIS) and other federal, state and local programs that might be able to provide assistance to an individual. These two disclaimers – that the TPMO does not sell all plans that are available, along with reference to SHIPs, an unbiased source of information that can counsel on all plans available – are critically linked. A referral to 1-800-MEDICARE alone is wholly inadequate.

Rather than removing reference to SHIPs in TPMO disclaimers, CMS should be actively promoting SHIPs, including as a check on agent and broker misconduct instead of sidelining the SHIP program. Should CMS proceed with this proposal, it would signal a clear capitulation to the insurance industry and a regrettable rollback of an important consumer protection.

*Removing Rules on Time and Manner of Beneficiary Outreach (§§ 422.2264, 423.2264, 422.2274, and 423.2274) (p. 54951)*

CMS proposes a number of changes relating to “beneficiary outreach” on the part of insurers and agents and brokers, including rescinding the current 12-hour delay requirement between an educational event and a marketing event, eliminating the 48-hour delay between completing a scope of appointment (SOA) form, and allowing SOAs to be collected at educational events. CMS claims that “[i]n total, these proposals and clarifications are designed to improve the enrollment decision-making process by creating a more convenient, beneficiary-friendly outreach experience and to reduce the burden on beneficiaries, plans, and agents/brokers” (p. 54951). **The Center for Medicare Advocacy strongly objects to these proposals, as they are far more advantageous to insurers, agents and brokers and remove important consumer protections. For the reasons outlined below, we urge CMS to rescind these proposals.**

With respect to rescinding the current 12-hour delay between educational and marketing events, CMS states: “based on a lack of evidence of a quantifiable protection to the beneficiary from the existing regulatory requirement, CMS believes that the beneficiary protections that CMS previously identified in the April 2023 final rule have not materialized” (p. 54952). CMS does not further define what “evidence of a quantifiable protection to the beneficiary” might be in this instance: reduced reports of marketing misconduct? A decline in the number of requested Special Enrollment Period (SEP) requests to correct marketing misconduct? Fewer enforcement actions against agents and brokers licensed in individual states? Without defining what evidence CMS

was seeking, and now relying on the absence of, the agency should not rescind a consumer protection that, as explained below, serves as an important check on aggressive sales tactics used against individuals merely seeking information at educational events.

Instead of further explaining the lack of evidence, CMS relies upon undisclosed and unquantified “stakeholder input” that very likely is comprised of self-interested agents, brokers and insurers: “CMS believes, based on stakeholder input, that the 12-hour delay requirement between an educational event and a marketing event may also create an unnecessary barrier to accessing important MA and Part D information for beneficiaries, especially those who live far from the events or those who lack access to transportation” (p. 54952). Did this input come from beneficiaries complaining about this “unnecessary barrier” or rather did it come from agents and brokers who are inconvenienced by this delay? If CMS’ concern is about beneficiaries accessing important information – which it should indeed be concerned about – this is the goal of educational events. Marketing events are aimed at convincing people to enroll in a specific plan – CMS should be less concerned about access to these events.

CMS asserts that it is:

reconsidering these previous positions [...] because for vulnerable beneficiaries, especially those in SNPs, it is common to have caregivers or other friends or family members provide assistance in gathering information on plan options (and often ultimately make decisions on behalf of the beneficiary), thus, there is often a built-in layer of added protection from any potential undue pressure.

CMS does not disclose, however, data upon which it relies to make an assertion that it is “common” for beneficiaries to be accompanied by others who have their best interests in mind. Nor does it account for the fact that such caregivers, friends and relatives can also be misled and subject to misinformation and misconduct. Further, using CMS’ rationale that people who bring other people are better protected, it begs the question about the plight of individuals who are unaccompanied. Does the fact that some people have others to look out for them compensate for those who do not? Would this dynamic not make unaccompanied individuals more of a target of agents and brokers?

CMS also notes that there are:

various beneficiary protections in place, including the possibility of providing special enrollment periods (SEPs) when appropriate, or, if warranted, processing a retrospective enrollment to place the beneficiary back into their prior coverage, if a beneficiary makes an adverse enrollment decision based on misrepresentation or otherwise noncompliant sales tactics. CMS thus proposes that plans and agents/brokers should be able hold an educational event and a marketing event back-to back and in the same location (p. 54952).

CMS again employs flawed rationale to justify this change; just because there is a potential avenue available to correct misconduct after the fact does not justify allowing conditions that are more likely to lead to misconduct.

CMS outlines the limited remaining consumer protections that would be in place if this proposal is finalized:

agents/brokers would be required to notify the beneficiary that the educational event is ending and a marketing event will begin shortly. Examples of appropriate beneficiary notification might be in the form of a verbal announcement at the educational event or a clear and distinct notation on a written schedule of the day's event. In addition to the beneficiary notification, CMS is proposing that plans and agents/brokers would also be required to give the beneficiary a sufficient opportunity to leave the educational event prior to the start of the marketing event" with an example of a "brief restroom or snack break."

In short, CMS is proposing a wholesale policy reversal with little to no rationale, other than addressing "burden" on agents and brokers. We have been down this road before. In outlining the history of the rules surrounding the distinction between marketing vs. educational events (at p. 54952), CMS fails to mention that prior to the January 2021 final rule, CMS made substantive changes to the Medicare Communications & Marketing Guidelines (MCMG) in 2019. As discussed below, prior to those revisions, marketing and educational events were distinct in time and place.

#### Summary of Previous Comments Objecting to Proposed Changes

Because history tends to repeat itself, including when reimposing faulty policy from the past, here we provide lengthy excerpts of CMA's previous comments on this topic. For example, below are excerpts from comments CMA submitted to CMS dated April 6, 2020 in response to the proposed 2021 and 2022 rule (CMS-4190-P)<sup>13</sup> followed by subsequent comments on the subject. All of these comments are relevant to CMS' current proposal to again rescind the 12-hour delay between educational and marketing events.

After objecting to the manner in which CMS proposed to codify sub-regulatory guidance contained in the Medicare Communications & Marketing Guidelines (MCMG), in our comments to the proposed 2021 and 2022 rule we outlined our original objections to the 2020 revisions to the MCMG provisions concerning the difference between marketing and educational events, including time and place distinctions, as well as CMS' utter failure to address this issue in the 2020/2021 proposed rule.

Our comments also quoted at length from an August 2019 letter to CMS in which we joined the Medicare Rights Center, Justice in Aging and the National Council on Aging in expressing concerns about revisions to marketing guidelines (hereinafter referred to as "joint letter"):<sup>14</sup>

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<sup>13</sup> CMA comments to the proposed 2021 and 2022 rule are available here: <http://medicareadvocacy.org/wp-content/uploads/2020/04/CMA-CD-Comments-2020.pdf>

<sup>14</sup> Joint letter from Center for Medicare Advocacy, Medicare Rights Center, Justice in Aging and National Council on Aging (dated August 27, 2019) is available here: <https://www.medicareadvocacy.org/joint-letter-concerning-medicare-plan-finder-and-marketing-materials/>.

Regarding the content, troublingly, the revised guidelines weaken the distinction between “marketing” events, which are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans; and “educational” events, which are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs.

Such changes appear to directly conflict with current law. Section 103 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) prohibits “Sales and marketing activities for the enrollment of individuals in Medicare Advantage [and Part D plans] plans that are conducted” at educational events; similarly, 42 C.F.R. §§ 422.2268 and 423.2268(b)(8) state that “in marketing” MA and Part D plans, sponsors may not “Conduct sales presentations or distribute and accept plan applications at educational events.”

The new MCMG revisions are inconsistent with these requirements. For example, they eliminate the current requirement regarding unsolicited contacts that restricts when an agent or broker can contact someone by removing the following language from the 2019 guidelines: “If a potential enrollee provides permission to be contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.”

Further, the revised guidance removes language requiring marketing appointments generated from an educational event to be distinct in time and place; the revisions delete “future” from the current language, which now reads that agents or brokers “May set up a future marketing appointment, and distribute business cards and contact information for beneficiaries to initiate contact (this includes completing and collecting a Scope of Appointment (SOA) form).” And the subsequent requirement—that an agent or broker “[m]ay not conduct a marketing/sales event immediately following an educational event in the same general location (e.g., same hotel)” is eliminated entirely.

In sum, the updated guidance seemingly allows educational events (which have fewer restrictions and no reporting requirements to CMS) to immediately turn into marketing events. While the guidelines still note that educational events “[m]ust not include marketing or sales activities or distribution of marketing materials or enrollment forms,” it appears that an agent or broker could immediately step out of the room, so to speak, and conduct a sales event. This defeats the purpose of delineating these types of events, and likely violates both the spirit of MIPPA and its implementing regulations.

The distinction between educational and marketing events was created, in part, so that beneficiaries would not be pressured to enroll in an MA or Part D plan during an educational event. While the distant time and location requirements separating these two types of events might inconvenience an agent/broker who wishes to sell a product to a prospect who appears interested immediately following an educational event, this changes the tenor and dynamic of educational events. Presumably individuals show up for educational events because they are advertised as such; if they were interested in engaging in a possible sale they have opportunities

to do so, whether it is through an advertised marketing session, through an individual agent/broker, or directly through a plan. If agents/brokers can immediately make a sale after an educational event, it turns such events that were designed to be without pressure into a hunting opportunity for agents/brokers or plan representatives. The previous requirements mandating that any marketing events occur distant in both time and place allowed a cooling off period for beneficiaries between an event where they came to learn and one in which they are being pressured to buy something. Now that this distinction is blurred, the same disclosures and reporting requirements that apply to marketing events should apply to educational events.

In the proposed 2020/2021 rule, we noted that CMS failed to address what had previously been a clear statutorily-required distinction between marketing and educational events, including differences in time and place. We also addressed proposed language to a rule stating that “If a marketing event directly follows an educational event, the MA organization or agent/broker must provide an opportunity for beneficiaries to determine if they want to continue onto the marketing event.” This is similar to what CMS appears to be proposing in the current proposed rule.

As we noted at the time, this language was vague beyond any usefulness, and apparently leaves it entirely to the agent/broker to determine if consent is given by the beneficiary “to continue onto the marketing event.” Can this meager requirement be satisfied if an agent/broker says “so would you like to talk more about [Plan X]?” or “Shall we?” or merely if the beneficiary fails to verbally object?

Similar to the first rescission of the delay between educational and marketing events, these current revisions appear to violate MIPPA. On its face, this proposal appears to be an end-run around the MIPPA provisions mandating a distinction between marketing and educational events. Other than the assertion that such provisions are compliant with the statute, CMS has an obligation to explain how this is so.

After CMS went ahead with the initial rescission of the delay between educational and marketing events, CMA and other organizations representing beneficiaries continued to object. Here we provide an excerpt from our comments to CMS’ proposed 2023 rule,<sup>15</sup> urging the agency to reinstate the firm distinction between marketing and sales events.

With respect to the specific changes concerning marketing vs. educational events, in the preamble to the final 2021 rule, CMS noted that “a commenter expressed concern” that the proposed rule would “allow agents or brokers to set up marketing appointments directly following educational events.” Instead of addressing our allegation that this change could violate MIPPA, CMS dodged the issue by stating that “[t]he policy decision to allow marketing and educational events to occur in a close physical and time proximity predates this rulemaking, as

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<sup>15</sup> CMA comments available here: <https://medicareadvocacy.org/cma-comments-on-2023-part-c-and-part-d-payment-policies/>.

reflected in CMS’s August 6, 2019 Medicare Communications and Marketing Guidelines Update Memorandum [...]” (86 FR 5989). The only rationale for this change CMS offered was that it:

made this change because it can be burdensome for beneficiaries to travel to events. If the beneficiary attends an educational event and wants to hear more plan specific information via a sales event, we believe it should be allowed to happen around the same time, rather than requiring the beneficiary to return on a different day or to a different venue. We, however, share the concern regarding the meeting type switching without the beneficiary being aware. As such, we are further strengthening the language proposed at §§ 422.2264(c)(2)(i) and 423.2264(c)(2)(i), to require that a beneficiary be made aware of a change from educational event to marketing event and given the opportunity to leave prior to the event beginning. In addition, if a beneficiary is attending a personal marketing appointment with a plan representative, the representative would need to have the beneficiary complete a scope of appointment (SOA) form prior to any discussion [...]” (86 FR 5989).

It stresses credulity to assert that this change was made to cater to beneficiaries, rather than the Medicare Advantage and Part D industry. At the very least, CMS agreed with our comment about the inadequacy of the language in the proposed rule with respect to requiring “the agent/broker to provide an opportunity for the beneficiary to determine if they want to continue to a marketing event directly following an educational event. The commenter stated this was too vague, resulting in the agent/broker determining if the beneficiary has given consent” (86 FR 5988). In the preamble, CMS stated:

We agree with this concern in part and have strengthened the language at §§ 422.2264(c)(2)(i) and 423.2264(c)(2)(i) that requires agents and brokers make the beneficiary aware of a change in meeting type from educational to marketing and to provide the opportunity for beneficiaries to leave prior to the start of the marketing event. With this change from the proposed rule, we do not believe that the regulation text is vague or requires the agent, broker or other plan representative to guess whether a beneficiary wishes to remain for the marketing event. We also note that agents and brokers, as downstream entities of plans, must abide by the requirements in Subpart V of this rule, including §§ 422.2262(a)(1)(iii) and 423.2262(a)(1)(iii), which prohibits them from engaging in activities that could mislead or confuse Medicare beneficiaries (86 FR 5988-9).

Unfortunately, CMS did not much improve the final language at §422.2264(c)(2)(i), which states: “If a marketing event directly follows an educational event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning” (p. 6107).

This still-vague requirement remains susceptible to manipulation by agents, brokers and other plan representatives. Absent a strict disclaimer or other required language that must be read or provided to attendees that clearly describes the scope and purpose of an educational event vs. a marketing event, this regulatory requirement is essentially useless. One need not employ much imagination to see how such transitions will be described by marketers as merely “shifting

gears”, “getting into more detail”, etc., and how attendees will be reminded that they are “free to leave” at any time.

In short, CMS has both failed beneficiaries by codifying this change, and failed to explain how such change does not violate either the letter or the spirit of the law meant to protect consumers. At the very least, CMS is obligated to provide clearly articulated rationale for why these changes don’t violate the MIPPA provision cited above. A better solution would be to reverse these changes altogether.

#### Previous Comments in Support of Reinstating Distinction Between Marketing and Educational Events

When CMS proposed to reinstate the more firm distinctions between marketing vs. educational events in the proposed 2024 rule, CMA strongly supported CMS’ action and its rationale. As we noted in our comments to the proposed 2024 rule,<sup>16</sup> CMS stated that since the 2021 final rule, “complaints to CMS have increased alleging unsolicited contact. We believe that some of these complaints may be attributed to the collection (and later use) of contact information or SOA cards at educational events” (p. 79529). CMS also noted that it had heard from beneficiary groups requesting that CMS reinstate the beneficiary protections from the MCMG that were not included in the January 2021 final rule regarding educational events. The Center for Medicare Advocacy acknowledged that we were one of those beneficiary groups and had been pushing for such reinstatement ever since the consumer protections were removed.<sup>17</sup>

As we have repeatedly asserted to CMS – and do so again now, these changes appear to directly conflict with both the plain text and intent of Section 103 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which prohibits “Sales and marketing activities for the enrollment of individuals in Medicare Advantage [and Part D plans] plans that are conducted” at educational events.

We expressed gratitude to CMS for reversing course in the proposed 2024 rule and reinstating these important consumer protections that reimposed a barrier between educational and sales events. We could not agree more with CMS’ statement that “We believe the beneficiary needs to be in charge of and control whether they want to be contacted, by whom, and in what form” (p. 79529).

Accordingly, we strongly supported CMS’ proposal to reinstate the prohibition on accepting Scope of Appointment (SOA) cards or the collection of beneficiary contact information at educational events, since such events are “meant to provide generic information about the different options, rather than to persuade beneficiaries to enroll in any type of plan (for example, MA–PD or Medigap) or in a plan offered by any specific sponsoring organization” (p. 79529).

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<sup>16</sup> CMA comments available here: <https://medicareadvocacy.org/wp-content/uploads/2023/02/C-and-D-Comments-CY-2024.pdf>

<sup>17</sup> See, e.g., CMA Comments to Proposed CY 2021 and 2022 Part C&D rule (April 2020), available at: <https://www.medicareadvocacy.org/wp-content/uploads/2020/04/CMA-CD-Comments-2020.pdf>.

We also strongly supported CMS' proposal to prohibit organizations and agents from setting up future marketing appointments at educational events, for all of the reasons CMS articulated in the preamble of the proposed 2024 rule. We also strongly supported CMS' proposal to prohibit marketing events from taking place within 12 hours of the educational event in the same location. As CMS noted, this will alleviate pressure or obligation beneficiaries may feel into staying for marketing events offered at the conclusion of educational events. CMS should not be swayed by any arguments from the agent/broker community that reinstating these barriers will be an inconvenience for beneficiaries (rather than themselves). As CMS noted at the time, "If a beneficiary attends an educational event and wants further information about a specific MA or Part D product, the beneficiary can go to a marketing event or ask for a one-on-one appointment either in person or through communications technology" (p. 79530). As CMS noted, a 12-hour window will help give beneficiaries "sufficient time to think about the impartial and factual information provided at the educational event" as opposed to a short window of time permissible under current rule.

In short, CMS now proposes to resuscitate a flawed rollback of an important consumer protection by essentially eliminating the distinction between educational and marketing events. CMS offers no new rationale, other than input from undefined stakeholders and defective rationale that consumers would be adequately protected because some of them bring other people to agent/broker events, and there are corrective measures available, such as SEPs, if misconduct occurs. CMS is again proposing a wholesale policy reversal that would benefit the insurance industry and those who sell their products, while hiding behind thin explanations that it will be beneficiaries who would be best served by such changes. We strongly object to this proposal and urge CMS to rescind it.

*Timing of Personal Marketing Appointment After Scope of Appointment (SOA) Form Completion* (p. 54953)

In the proposed rule, CMS outlines the history of Scope of Appointment (SOA) forms, including codification of the 48-hour SOA standard in the September 2011 final rule, which CMS subsequently removed in the January 2021 rule. In the April 2023 final rule, CMS reverted to the original 48-hour period. CMS now proposes to eliminate the 48-hour waiting period again, without a specified timeframe. **We object to this proposal and urge CMS to retain the 48-hour waiting period.**

As with the proposed rescission of the 12-hour delay between educational and marketing events discussed above, CMS characterizes the proposal to remove the SOA delay as primarily benefiting consumers, with ancillary benefits to agents and brokers: "CMS believes that the strict 48-hour SOA requirement may create an unnecessary barrier to accessing important MA and Part D information for impacted beneficiaries, and also barriers for plans and agents/brokers distributing this information, without offering a quantifiable protection to the beneficiary" (p. 54953). Similar to our comments to the proposed changes to educational vs. marketing events above, we note that CMS does not further define what "quantifiable protection to the beneficiary" might be in this instance: reduced reports of marketing misconduct? A decline in the number of requested Special Enrollment Period (SEP) requests to correct marketing misconduct?

Fewer enforcement actions against agents and brokers licensed in individual states? Without defining what evidence CMS was seeking, and now relying on the absence of, the agency should not rescind a consumer protection that, as explained below, serves as an important check on aggressive sales tactics used against individuals merely seeking information.

Also similar to the proposal to remove the 12-hour gap between educational and marketing events discussed above, CMS claims that there are “built-in” safeguards:

There is often a built-in layer of added protection from any potential undue pressure, as evidenced by the tendency for vulnerable beneficiaries to have other people help them with plan options and making decisions (for example, caregivers or authorized representatives), together with previously mentioned existing beneficiary protections if a beneficiary makes an adverse enrollment decision based on misrepresentation or otherwise non-compliant sales tactics. CMS is now reexamining the relative protection offered by these other factors and based on additional information that CMS has received about the relative benefit or burden of the 48-hour SOA rule” (p. 54954).

We reiterate our responses to similar rationale offered above. CMS does not disclose data upon which it relies to make an assertion that there is a “tendency for vulnerable beneficiaries to have other people help them” nor does it account for those who do not have such help. Using CMS’ rationale that people who rely on other people are better protected, it begs the question about the plight of individuals who don’t have such assistance. Does the fact that some people have others to look out for them compensate for those who do not? Would this dynamic not make unaccompanied or unassisted individuals more of a target for agents and brokers?

CMS also offers additional rationale that there are “previously mentioned existing beneficiary protections if a beneficiary makes an adverse enrollment decision based on misrepresentation or otherwise non-compliant sales tactics.” As we noted above, CMS employs flawed rationale to justify this change; just because there is a potential avenue available to correct misconduct after the fact does not justify allowing conditions that are more likely to lead to misconduct.

CMS also references “additional information that CMS has received about the relative benefit or burden of the 48-hour SOA rule.” What information and from whom? Without any disclosure, we can only assume that this feedback comes from self-interested parties such as agents, brokers and insurers, for whom the 48-hour rule is a “burden”, and does not originate from beneficiaries and those who represent them.

CMS also proposes additional changes to the SOA, including clarifying “that Business Reply Cards (BRCs), voicemails, online forms, or other requests for information that include the type of product(s) to be discussed are, in effect, SOAs. CMS currently does not provide a model document for SOAs.” **We object to these proposals that would greatly expand the scope of communications between agents/brokers and prospective clients that would be considered SOAs.** It does not take much imagination to envision how minimal contacts from beneficiaries will, against their wishes or understanding, be interpreted by agents and brokers as permission to aggressively sell them products. Instead of pointing out that CMS does not provide a model document for SOAs the agency should provide and require one.

CMS continues: “the signed SOA can be used for multiple telephonic or in-person contacts or appointments. With that said, a plan or agent/broker should respect a beneficiary’s request to no longer be contacted, even if that additional contact would take place within the 12-month window.” We note that CMS offers a mere suggestion – the agent/broker “should” respect beneficiaries’ wishes rather than “must.” Instead of making things as lenient and lax as possible for those who sell Medicare products, CMS should focus more on and offer stronger protection to those who are enrolled in Medicare. The Center for Medicare advocacy opposes CMS’ proposed changes to the SOA and urges the agency to reject them.

*Scope of Appointment (SOA) Forms at Educational Events (p. 54955)*

In line with other proposed changes in this proposed rule to the conduct of Medicare sales, “CMS is proposing to rescind these requirements as finalized in the April 2023 final rule and revert to the language established in the January 2021 final rule, to permit plans and agents/brokers to obtain SOA forms at educational events” (p. 54955).

After declaring that this proposal is compliant with the statute because “[t]he collection of an SOA form is not a sales or marketing activity but is the making of an agreement regarding what type of product(s) will be discussed in advance of a personal marketing appointment between the beneficiary and the plan or agent/broker” CMS describes how this change would alleviate the “burden” on beneficiaries. CMS has forgotten its own rationale, provided in its proposed 2024 rule, to reinstate the prohibition on accepting SOA cards or the collection of beneficiary contact information at educational events, since such events are “meant to provide generic information about the different options, rather than to persuade beneficiaries to enroll in any type of plan (for example, MA–PD or Medigap) or in a plan offered by any specific sponsoring organization” (p. 79529).

CMS then tries to explain why it is reversing course, and:

acknowledges that this proposal reflects a change in the agency’s position as described in the April 2023 final rule where CMS most recently adopted the ban on collecting SOA forms at educational events. For example, as part of its previous reasoning, CMS stated that it was concerned that beneficiaries may feel uncomfortable refusing to fill out an SOA form, or that they may feel obligated to provide this information in exchange for attending an educational event. Upon reconsideration, CMS now recognizes that these concerns regarding beneficiary pressure appear to be outweighed by the importance of maximizing beneficiary access to information on available plan options, which could be accomplished by allowing the collection of SOA forms at educational events. In addition, as previously mentioned, there are also beneficiary protections in place should a beneficiary make an adverse enrollment decision based on misrepresentation or otherwise noncompliant sales tactics (p. 54956).

As we raised in comments to other proposed changes to the sale of Medicare products discussed in this proposed rule, CMS fails to articulate how and why it “now recognizes that these concerns regarding beneficiary pressure appear to be outweighed by the importance of

maximizing beneficiary access to information on available plan options” – based on what? Agent, broker and insurance industry feedback? As outlined above in our comments to the proposal to remove reference to SHIPs in TPMO disclaimers, such organizations along with individual agents and brokers are not obligated to contract with or sell every available plan in a given area and are highly motivated by commissions that drive enrollment in certain plans that don’t necessarily align with individual beneficiaries’ interests. This dynamic makes CMS’ expressed concern about “the importance of maximizing beneficiary access to information on available plan options” ring hollow. If this is truly an agency concern, CMS would exert considerably more effort promoting and supporting the SHIP program, rather than focusing on the needs of industry and removing references to SHIPs in TPMO disclaimers. Finally, as noted above, CMS’ mention of available consumer protections is inadequate rationale to justify this change; just because there is a potential avenue available to correct misconduct after the fact does not justify allowing conditions that are more likely to lead to misconduct.

CMS’ proposals do not “improve rules regarding beneficiary outreach” (p. 54957), rather they serve to gut consumer protections in order to further unleash agent/brokers. The Center for Medicare Advocacy objects to this proposal and urges CMS to rescind it.

*Relaxing the Restrictions on Language in Advertising (§§ 422.2262(a)(1)(i), 422.2262(a)(1)(ii), 423.2262(a)(1)(i), and 423.2262(a)(1)(ii))* (p. 54956)

CMS proposes to allow MA organizations to use superlatives in advertising, without the need to support the superlative with sources of documentation or data, deeming current restrictions on the use of superlatives “unnecessary” (p. 54956). **We object to this proposal.**

CMS states that this proposal “will not affect the existing beneficiary protections, which will still be in effect, but will reduce the administrative burden for all parties” (p. 54957). It is difficult to see how prohibiting the use of superlatives constitutes any “administrative burden for all parties” – including, presumably, beneficiaries. Perhaps insurance plan marketing and advertising departments will feel unburdened in their creative efforts to convince people to enroll in their products, but allowing superlatives in advertising does not help beneficiaries compare the differences between plans and make informed decisions about their Medicare coverage options.

We note that if CMS considers plan efforts to collect documentation or data to support superlative claims to be an unnecessary administrative burden, but claims that it reserves the right to request such information from plans, this signals an intent on CMS’ part to neglect its oversight role with respect to plan advertising.

*Third-Party Marketing Organization (TPMO) Oversight: Revising the Record Retention Requirements for Marketing and Sales Call Recordings (§§ 422.2274(g)(2) and 423.2274(g)(2))* (p. 54957)

While CMS plans to keep the requirement that enrollment records be retained for 10 years, CMS proposes to reduce the number of years MA organizations must retain recordings of sales and

marketing calls from 10 years to 6 years. If part of the rationale in retaining enrollment records is to retain evidence of potential marketing/enrollment misconduct, allowing destruction of call recordings 4 years before enrollment records can be destroyed makes no sense from an enforcement standpoint. This appears to be yet another attempt to reduce “administrative burden” for agents, brokers and plans at the expense of regulatory oversight of misconduct. Noting that plans would still be required to record the “enrollment portion of the call” for enrollments that occur over the phone, but can delete the rest of the call that could contain the misleading statements signals that the agency is not serious about its oversight of such calls.

CMS contemplates even shorter retention periods along with “other, less expensive means” of record retention, including written transcripts. CMS correctly raises the question of whether “current technology [can] automate the transcription with sufficient accuracy.” CMS goes even further by stating “based on the mixed findings from the review of call recordings, CMS is also considering, as an alternative, whether maintaining a recording, either audio or otherwise, of the marketing and sales portion of calls is necessary at all.” CMS correctly points out that this would mean that the agency and other oversight organizations would not have the ability to directly review agent and broker behavior.

As discussed above in our comments concerning other proposed changes to the marketing and sale of Medicare products, misconduct remains a significant problem for beneficiaries. Deregulatory efforts to unburden agents, brokers and Medicare plans from proper accountability is an abdication of CMS’ regulatory and oversight role of the Medicare marketplace. Discarding the ability to “directly review agent and broker behavior” gives a free pass to those who engage in misconduct. CMS should strengthen oversight of the industry and provide for stronger consumer protections, not pursue the opposite course. **The Center for Medicare Advocacy objects to these deregulatory proposals.**

*Rescinding the Requirement for the Notice of Availability (§§ 422.2267(e)(31) and 423.2267(e)(33)) (p. 54959)*

CMS proposes to eliminate the requirement to make Notices of Availability (stating that the MA organization will provide language assistance services and auxiliary aids free of charge, in English and 15 other languages) available to beneficiaries. CMS defers to the HHS Office of Civil Rights (OCR) regarding oversight and management of any requirements related to language assistance and auxiliary aids.

**CMA opposes the proposed rescission.** We would like to express support for keeping the requirement for plans to provide a Notice of Availability in all the required documents and languages specified in the Medicare regulation (at 422.2267(e)(31) and 423.2267(e)(33)), as it gives Medicare enrollees clear notice that access to interpretation is free.

The Notice of Availability can help individuals get language assistance services or auxiliary aids empowering individuals to manage their health coverage and reduces burdens on community-based organizations with limited resources that would step in to assist without these services. Without this assistance individuals will face barriers to care due to lack of access to

interpretation or other communication access issues with Medicare Advantage and Prescription Drug plans.

## **V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184) (p. 54964)**

### C. Adding, Updating, and Removing Star Ratings Measures

We commend CMS for continuing to improve the Part C and Part D Star Ratings system by focusing on improving clinical and other health outcomes. **CMA supports CMS’s proposal to add “Depression Screening and Follow-Up” as a new MA Star measure.** Suicide rates are higher and rising in older adults than in any other age group,<sup>18</sup> and it is vital that depression and other mental illnesses be timely identified so Medicare beneficiaries can be connected to appropriate care. Given the significant role MH and substance use have in an individual’s health and wellbeing, we believe adding this measure will be consistent with CMS’ goal of preventing and managing chronic disease and ensuring that MA enrollees have access to quality care.

Relatedly, **we strongly encourage CMS to add the “Initiation and Engagement of SUD Treatment” (IET) Star measure to Part C.** Just like the Depression Screening and Follow-Up measure, IET is nationally endorsed and in alignment with the private sector, and would provide an appropriate SUD counterpart to the currently proposed MH measure. In fact, CMS proposed adding this composite SUD measure in the CY26 MA proposed rule,<sup>19</sup> and it is even more important now that MA plans be transparent in their provision of SUD care as the opioid public health emergency continues.<sup>20</sup> As CMS noted at the time, MA contracts have been collecting this data for over ten years, so adding this to the Star Ratings will not increase the burden or cost for plans.

At the same time, adopting this measure will ensure that MA plans are appropriately investing in access and removing barriers to SUD treatment. Recent research shows that MA plans are currently performing significantly worse than traditional Medicare – and much worse than Medicaid – on these two measures: only 23% of MA enrollees initiated SUD treatment as compared to 36% in traditional Medicare; and only 7% of MA enrollees engaged in (continued) treatment, as compared to 15% in traditional Medicare.<sup>21</sup>

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<sup>18</sup> Chloe Zilkha, Vani Agarwal, & Richard G. Frank, “Suicide Rates Are High And Rising Among Older Adults in the US,” *Health Affairs Forefront* (Mar. 4, 2024), <https://www.healthaffairs.org/content/forefront/suicide-rates-high-and-rising-among-older-adults-us>.

<sup>19</sup> 89 Fed. Reg. 99340, 99474 (proposed Dec. 10, 2024).

<sup>20</sup> U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, “Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis,” ASPR (Dec. 15, 2025), <https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-15Dec2025.aspx>.

<sup>21</sup> Tami L. Mark et al., “The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid,” *Health Affairs* 44(9), 1086-1091 (Sept. 2, 2025), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207>.

**CMA opposes CMS’ proposal to remove the Health Equity Index (HEI) reward and replace it with the historical reward factor, and urges CMS to withdraw this proposal.** Research consistently shows that the Star Ratings system does not improve quality of care for Medicare beneficiaries. Rather, it seems to embed disparate quality standards into the MA and Part D system. The HEI reward provided an appropriate incentive for plan sponsors to level the playing field and invest in quality improvements for dually eligible, low-income, and disabled beneficiaries. For this reason this reward was of value to beneficiaries and should be continued. By contrast, the historical reward factor has no bearing on improving clinical care, outcomes, or patient experience, as CMS contends. There is ample evidence that these plans are consistently denying patients needed care, both directly and indirectly.<sup>22</sup> It seems counterintuitive that these plans should be rewarded for doing so, at the same time that CMS suggests that the quality system needs to be dramatically modified because it is failing to achieve its purpose. This measure would lead to higher payments for plans without any incentive for improving outcomes. We urge CMS to withdraw this proposal, and allow plans to continue to move forward with the HEI investments they have been making over the past several years in preparation for this reward system to go into effect.

**CMA opposes the CMS proposal to remove quality metrics measuring whether Medicare Advantage Plans provide access to foreign language interpreters and Deaf communication access (via TTY).** While we understand the reasoning behind this change that plans have very high performance on these metrics and there is little variation across plans, we urge CMS to consider alternatives to ensure this care issue is reflected in the ratings.

We support quality metrics that measure whether individuals are provided with required language interpretation and Deaf communication access. This is a core component of quality and CMS should consider alternatives to scoring these measures before removing them completely.

**Similarly, CMA opposes the CMS proposal to eliminate measures of how plans respond to appeals of claim denials.** Again, while we understand the reasoning behind this change that plans have very high performance on these metrics and there is little variation across plans, we urge CMS to consider alternatives to ensure that this critical consumer protection is reflected in the ratings.

**CMA also opposes the CMS proposal to remove the “Members Choosing to Leave the Plan” measure.** This measure assesses critical aspects of MA plan quality and enrollee satisfaction with the plan. It is critical to maintain a measure that is clearly tied to how well enrollees view their plan is meeting their needs, providing quality care, with access to their providers, services and treatments; if the plan is not and they opt to disenroll, this information should be captured by the measures.

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<sup>22</sup> “Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020,” Legal Action Center (Oct. 2024), <https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf>.

## **VI. Improvements for Special Needs Plans (p. 54970)**

States are a key partner in monitoring D-SNP activities and acting to improve enrollee access to care. **CMA agrees with changes CMS is proposing that would improve a state’s ability to engage in D-SNP oversight: Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination**, in which CMS proposes to codify a pathway for terminating a D-SNP contract that is not in compliance with state requirements; and **Limitations on D-SNP-Only Contracts Submitting Materials under the Multi-Contract Entity Process**, in which CMS proposes to require D-SNPs and other entities to submit materials to a CMS portal in a manner that allows states to review those materials.

CMA would like to express strong support for these proposed enhancements that allow states to monitor the activities of D-SNPs (such as oversight of marketing, enrollee access to care, and other issues) and take action if D-SNPs are not providing adequate access to care.

However, CMA is very concerned about the expansion in passive enrollment in D-SNPs that would override a person’s decision to enroll in traditional Medicare, with the only notice of the passive enrollment coming from the new plan once beneficiaries are enrolled. Additionally, it is important to note here that there is no research to provide evidence that D-SNPs provide improvements in care coordination for dually eligible beneficiaries. Beneficiaries will not benefit from this change and undermining beneficiary choice is harmful. We oppose this policy as it is misguided and would not improve coordination of care.

## **VII. Reducing Regulatory Burden and Costs in Accordance With Executive Order (E.O.) 14192 (p. 54984)**

*Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42))* (p. 54987)

**CMA strongly opposes this proposal to rescind mid-year supplemental benefits notices.**

Virtually all MA plans provide supplemental benefits,<sup>23</sup> however they are not standardized and vary by plan. Research demonstrates that while beneficiaries value supplemental benefits in theory, and these benefits are a major driver in plan selection, many enrollees do not utilize the full range of supplemental benefits available to them.<sup>24</sup>

Due to concerns with underutilization of supplemental benefits, CMS’ CY2025 Final Rule required plans to issue annual notices to beneficiaries of “Mid-Year Enrollee Notification of Unused Supplemental Benefits.”<sup>25</sup> These personalized notices were going to include a list of the supplemental benefits that have not been used by the beneficiary during the first half of the plan

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<sup>23</sup> KFF, “Medicare Advantage 2023 Spotlight: First Look”, (Nov. 10, 2022): In 2023, 97% or more individual plans offer some vision, fitness, telehealth, hearing or dental benefits.

<sup>24</sup> Science Magazine, “Medicare Advantage Beneficiaries Show No Increase in Dental, Vision, or Hearing Care Access” (Jan. 14, 2025).

<sup>25</sup> CMS, Final Rule, 89 Fed. Reg. 30448 (Apr. 23, 2024); see also CMS, “Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)” (Fact Sheet), April 4, 2024.

year, and were to begin June 30-July 31, 2026. The notices were to include details about the network requirements, the scope of the benefits, cost sharing, and a customer service number. The planned notices were to be limited to supplemental benefits that had not been accessed by the beneficiary, not a listing of all supplemental benefits available to any enrollee in the plan.

The proposed rule states that it is rescinding the requirement because it “would impose a significant burden on MA organizations that outweighs the intended benefit.”<sup>26</sup> If this proposal is finalized, Medicare Advantage enrollees will miss out on important information about benefits available to them.

A recent Commonwealth Fund report, “Could Notifications Help Medicare Advantage Beneficiaries Utilize Their Unused Benefits?”<sup>27</sup> highlighted the underutilization of benefits.

The report found that in 2024, three of 10 MA beneficiaries reported not using any supplemental benefits. “Less than half used dental, vision, gym memberships, or over-the-counter drug allowance benefits, and less than 10 percent used benefits like hearing, grocery allowance, or meal delivery. If the benefits are not used, the insurers are permitted to keep any unspent funds.”<sup>28</sup>

Additionally, the report found a strong desire among beneficiaries to receive more information about their unused supplemental benefits. “Eight of 10 MA enrollees said that they would like to receive notifications about their unused benefits. . . Of those who wanted to receive these notices, a similar share indicated a preference for receiving them once a year (43%) versus more than once annually (57%).”<sup>29</sup>

We understand that some insurers are concerned about a huge influx of beneficiaries attempting to use their unused benefits at the same time as a result of the mid-year notices alerting them to unused benefits. CMA would respond to this concern that we urge CMS to require additional notices provided quarterly so that fewer people attempt to use the benefits at the same time. Other approaches could also be explored, but deciding not to issue notices at all is not an acceptable response to this industry concern. Supplemental benefits are designed and marketed to aid in healthy aging. If beneficiaries are not aware of the benefits available to them they will continue to forgo these benefits. We strongly oppose this proposal and urge CMS to require plans to provide these notices.

*Revisions to Ensuring Equitable Access to Medicare Advantage (MA) Services (§ 422.112(a)(8))* (p. 54988)

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<sup>26</sup> Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 90 Fed. Reg. 54894 (Nov. 28, 2025).

<sup>27</sup> Commonwealth Fund, “Could Notifications Help MA Beneficiaries Utilize Benefits?” (Oct. 30, 2025).

<sup>28</sup> Id.

<sup>29</sup> Id.

**CMA is opposed to the proposed changes in Revisions to Ensuring Equitable Access to Medicare Advantage (MA) Services.** We support keeping in place in-care access regulations and references to specific groups that have historically experienced discrimination in accessing Medicare services. We support keeping in place requirements for quality improvement activities to include the reduction of disparities. Anti-discrimination rules and quality improvement can protect access to care for individuals. We support enumerating groups that have experienced well-documented discrimination; we do not believe that explicitly stating types of groups of individuals would be confusing for plans. The rule states that it intends to maintain “the protections for access to services for all enrollees,” so we cannot see the harm in highlighting groups that have historically faced discrimination so that plans can ensure protections for those groups.

*Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7)) (p. 54988)*

**CMA opposes CMS’ proposal to remove the requirement that at least one member of the Utilization Management (UM) Committee have an expertise in health equity, that the UM Committee conduct an annual analysis of health equity and prior authorization, and that the resulting analysis be publicly posted on plan’s websites.** The UM Committee is responsible for reviewing the utilization management policies of MA plans and ensuring that they are consistent with traditional Medicare coverage requirements. It is important to maintain and strengthen these requirements. In order to ensure that MA plans are meeting coverage requirements, this analysis needs to be done and there must be transparency for policymakers, researchers, and the public.

*Rescinding the Quality Improvement Program Health Disparities Requirement (§ 422.152(a)(5)) (p. 54990)*

**CMA opposes the proposal to Rescind the Quality Improvement Program Health Disparities Requirement.** In the April 2023 final rule, CMS added a requirement at § 422.152(a)(5) that directs MA organizations to incorporate one or more activities that reduce disparities in health and health care as part of their QI program to comply with health equity mandates stemming from [E.O. 13985](#), “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.” The proposed rule states that rescinding this requirement allows plans to continue to “retain the flexibility to implement quality initiatives that address the needs of all enrollees. . . .to target health disparities.” We strongly believe that plans must be mandated to include these initiatives. Unfortunately, when plans have the room and flexibility to determine if they will target health disparities, we have seen that certain populations are disproportionately harmed. The April 2023 final rule aimed to bring populations that had been left behind on par with populations with higher quality care, and we urge the requirement to remain.

## **VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition) (p. 54991)**

### *Risk Adjustment (p. 54992)*

CMA is concerned about the manner in which plans are able to game the risk adjustment system as currently designed and inflate their scores in order to receive more money, without providing any additional services or care to enrollees. CMA supports making changes to the risk adjustment structure. The goal should be to make the measures less gameable and relevant to patient decision making, with a focus on patient experience, access to care and outcomes. CMA urges CMS to remove diagnosis codes that only come from chart reviews or health risk assessments that are not substantiated in other visits with medical providers. Without follow-up treatment and visits it is questionable whether a plan was simply inflating their scores.

CMA also urges CMS to increase the coding inflation adjuster beyond the current statutory minimum and potentially implement a variable coding intensity adjuster.

CMA is concerned that CMS is removing the disenrollment measure because that is an important sign of how well a plan is doing. For example, high disenrollment suggests the plan is probably not meeting enrollee care needs. Removal of the CAHPS (survey) measures is also concerning.

A recent majority staff report issued by the Senate Judiciary Committee under Sen. Chuck Grassley<sup>30</sup> highlighted the alarming manner in which plans, particularly UnitedHealth Group, are able to game the risk adjustment system in order to boost their scores and thereby their bottom lines. The report's conclusion states:

... UHG has been able to profit from the way that CMS risk adjusts payments to MAOs. The investigation has also shown that risk adjustment in MA has become a business in itself—by no means should this be the case. MAOs should receive payments that are commensurate to the complexity and acuity of the Medicare beneficiaries that they insure, not their knowledge of coding rules and their ability to find new ways to expand inclusion criteria for diagnoses. Taxpayers and patients deserve accurate and clear-cut risk adjustment policies and processes.<sup>31</sup>

As the recent report underscores, MA plans can generate billions in additional government payments by identifying and recording as many diagnoses as possible among their enrolled beneficiaries without treating these conditions or improving enrollee health outcomes or quality of life. The research supporting changes to the risk adjustment model is vast; we urge CMS to finally address this critical issue.

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<sup>30</sup> Senate Committee on the Judiciary, Majority Staff Reports, "How UnitedHealth Group Puts the Risk in Medicare Advantage Risk Adjustment," (Jan. 12, 2026).

<sup>31</sup> *Id.*

### *Quality Bonus Payments*

The evidence is clear that the quality bonus program, which is designed to hold MA insurers accountable to delivering high-quality care and coverage to Medicare beneficiaries, does not generate meaningful or consistent improvements in MA plan quality. One concern is that the quality is scored at the overarching contract level, even for contracts that cover large and disparate areas through multiple MA plans and plan designs. This means star ratings assigned to an individual MA plan do not necessarily reflect the quality a beneficiary would receive. We urge CMS to assess plan performance and calculate a star rating score at the plan or market level rather than the contract level, and focus on patient-experience outcome measures.

**Supplemental benefits eligibility transparency.** CMA recommends that CMS require plans to publish supplemental benefit eligibility criteria on their websites, in order to improve transparency and the ability for individuals to compare plans. CMA reiterates its request for CMS to publish data on supplemental benefit utilization disaggregated by demographics.

### **Align MA and Cost Plan Cost-Sharing for MH and SUD Services with Traditional Medicare to Improve Wellbeing for MA Enrollees**

CMA appreciates the opportunity to comment on wellbeing policy changes that CMS should consider in future years for the MA program. One such policy that would “improve overall health, happiness, and satisfaction in life that could include aspects of emotional wellbeing, social connections, purpose, and fulfillment” is to **align MA and Cost Plan cost-sharing for MH and SUD services with traditional Medicare fee-for-service cost-sharing**, as CMS proposed in the CY26 MA proposed rule.<sup>32</sup> Access to affordable MH and SUD treatment is vital for overall health and emotional wellbeing, and we strongly urge CMS to adopt this policy.

As CMS noted in that proposed rule, beneficiaries in traditional Medicare pay only 20% coinsurance for all services (with zero cost sharing for opioid treatment program (OTP) services), while MA enrollees may be charged up to 50% coinsurance for the same MH and SUD services. CMS’ data shows that approximately one in four MA plans have higher cost-sharing for MH specialty and psychiatric services than traditional Medicare, and individuals in these plans would save an average of \$7 per visit under the proposed change. The potential impact for access to SUD services is even greater: more than two in five MA plans have higher cost-sharing for outpatient SUD services than traditional Medicare, and individuals in these plans would save an average of \$30 per day under the proposed change. This means an individual enrolled in MA receiving outpatient SUD treatment just once a week would save over \$1500 annually, and we know many individuals receive treatment even more frequently than that.

Notably, 71% of MA plans have higher cost-sharing for OTP services than traditional Medicare, and individuals in these plans would save an average of \$47 per visit. These costs add up quickly

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<sup>32</sup> 89 Fed. Reg. 99340, 99401 (proposed Dec. 10, 2024).

for individuals who attend treatment daily, as required for many participants, and these numbers show that many MA enrollees with SUD are currently spending thousands of dollars out-of-pocket annually to access this lifesaving SUD treatment.

While these additional costs would be minimal for MA and Cost Plans, these savings would be life-changing for Medicare beneficiaries with SUD and MH conditions. Among Medicare beneficiaries with SUD, one of the most commonly reported reasons for not receiving treatment was financial barriers.<sup>33</sup> Additionally, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) found that Medicare beneficiaries with opioid use disorder (OUD) who receive the low-income subsidy are almost three times more likely (26% compared to 9%) to receive medications to treat their OUD than beneficiaries without the subsidy, identifying the high Part D cost-sharing (averaging \$268/annually for those without the subsidy, compared to \$19/annually for those with the subsidy) as a potential explanation for this disparity.<sup>34</sup> We have heard from many treatment providers and advocates that Medicare beneficiaries with SUDs feel like they have to choose between their SUD treatment – which is currently more affordable through traditional Medicare – and the other benefits that they might be able to receive through MA plans, like vision, hearing, and dental. No one should be forced into this position, and we believe this policy will help ensure that those who choose to enroll in MA plans do not have to sacrifice their wellbeing or their SUD and MH care needs.

Accordingly, we strongly encourage CMS to adopt this policy to align MA and Cost Plan in-network cost-sharing with traditional Medicare for SUD and MH services, consistent with CMS’s goals to improve wellbeing and to better prevent and manage chronic diseases.

MA and Part D plans are consistently and disproportionately failing Medicare beneficiaries who need SUD and MH care. Congress passed the bipartisan Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 to prevent these types of discrimination in health insurance, but tens of millions of Americans across the country are deprived of these consumer protections when they become eligible for Medicare, since it is not currently subject to this law. To the extent feasible, **we urge CMS to adopt policies and practices that facilitate greater parity between SUD and MH coverage and medical/surgical coverage.**

Even if full parity cannot be applied without Congressional action, we encourage CMS to **continue to improve access to SUD and MH services and medications by removing unnecessary treatment limitations.** For example, CMS should require all MA and Part D plans to remove cost sharing, prior authorization, step therapy, and dosage caps/quantity limits for medications for opioid use disorder (MOUD). These types of barriers all deter access to treatment, contributing to the disproportionately low rate at which Medicare beneficiaries with

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<sup>33</sup> William J. Parish et al., “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *American Journal of Preventative Medicine* 63(2), (Aug. 2022), <https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040>.

<sup>34</sup> U.S. Department of Health & Human Services Office of Inspector General, “The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern,” (Dec. 2023), <https://oig.hhs.gov/oei/reports/OEI-02-23-00250.pdf>.

OUD access this gold standard of care – fewer than one in five.<sup>35</sup> Accordingly, we strongly recommend CMS remove barriers to MOUD and other types of SUD and MH treatment as it continues to work with Congress towards parity.

## **Conclusion**

Thank you for the opportunity to provide these comments. For additional information, please contact David Lipschutz [DLipschutz@MedicareAdvocacy.org](mailto:DLipschutz@MedicareAdvocacy.org) or Kata Kertesz [KKertesz@MedicareAdvocacy.org](mailto:KKertesz@MedicareAdvocacy.org) at (202)293-5760.

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<sup>35</sup> U.S. Department of Health & Human Services Office of Inspector General, “Fewer than One in Five Medicare Beneficiaries Received Medication to Treat Their Opioid Use Disorder,” (Apr. 2025), <https://oig.hhs.gov/documents/evaluation/10253/OEI-02-24-00430.pdf>.