



Ohio Association of  
Area Agencies on Aging

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**Comments to Department of Health and Human Services  
Centers for Medicare & Medicaid Services: Attention: CMS-4212-P**

**RE: Medicare Program: Contract year 2027 Policy and Technical Change  
Program, Medicare Prescription Drug Benefit Program (CMS4212-P)**

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Ohio Association of Area Agencies on Aging  
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The Ohio Association of Area Agencies on Aging (o4a) appreciates the opportunity to provide comments on the proposed rule changes regarding the Medicare Program: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. O4a is a nonprofit network dedicated to helping older Ohioans, people with disabilities, and their families live independently and with dignity. We represent Ohio's 12 Area Agencies on Aging (AAAs), advocate for strong aging and disability policies, and connect communities to vital services like transportation, meals, caregiver support, and home and community-based care. Together, we work to ensure that every Ohioan has the resources and opportunities to age well at home and in their community.

Ohio's AAAs partner with four fully integrated D-SNPs which contract with our state to serve the dual population through the [Next Generation MyCare Ohio program](#). Ohio's AAAs assist in assessing individuals for eligibility and enrollment in the Next Generation MyCare Ohio waiver and help find the right services for them. As a stakeholder, we are submitting the following comments on behalf of our members and the individuals they serve.

**Increase Awareness of the State Health Insurance Assistance Program (SHIP)**

Section IV.E, page 57: In explaining this proposal, CMS indicates a strong preference against referring to SHIPs, indicating that counselors may not have the expertise to help enrollees navigate complex program issues. It has been our members' experience that Ohio's State Health Insurance Assistance Program (SHIP) counselors often possess substantially greater expertise than 1-800-MEDICARE representatives when responding to beneficiary questions and assisting with enrollment and plan selection—particularly in cases involving complex issues such as changes in provider networks or eligibility for Medicare Savings Programs.

While medicare.gov is an important and valuable resource, it can be difficult for many older adults to navigate and use effectively. In Ohio, for example, individuals dually eligible for Medicare and Medicaid are required to enroll in one of four contracted, fully integrated Dual Eligible Special Needs Plans (D-SNPs). Our members' experiences indicates that callers to 1-800-MEDICARE are not consistently

provided with accurate or complete information about enrollment into these plans or how they coordinate—or do not coordinate—with other Medicare coverage options.

Additionally, 1-800-MEDICARE staff are generally not familiar with Ohio's Next Generation MyCare Ohio program and are not trained to address questions specific to this model. In contrast, SHIP counselors receive targeted, ongoing training on state-specific policies and programs, including integrated care models, and regularly assist beneficiaries in navigating these complexities. SHIP counselors also coordinate effectively with the state Medicaid agency and with Area Agencies on Aging, ensuring beneficiaries receive accurate, consistent, and timely guidance tailored to their individual circumstances.

### **Protect Prohibitions on Misleading, Inaccurate, and Superlative Advertising**

Section IV.G on page 63: CMS proposes relaxation of marketing requirements, including deletion of a regulatory prohibition on giving inaccurate information, misleading information, and superlatives. We strongly oppose any relaxation of requirements designed to prevent inaccurate information, misleading marketing, or the use of superlative claims in plan materials and communications. We also strongly oppose the removal of requirements for plans to retain recordings of beneficiary calls, which are essential safeguards for oversight and accountability.

Over many years, our members have received reports from beneficiaries who were enrolled in plans without their informed consent following interactions with plan representatives. These inappropriate enrollment practices have resulted in beneficiaries losing access to established providers and experiencing significant disruptions in care. In some cases, these disruptions have led to delayed treatment during urgent or life-threatening situations, placing beneficiaries at serious risk.

### **Support Care Coordination for Individuals Enrolled in a D-SNP and Medicaid Fee for Service**

We strongly support all efforts to ensure that individuals who are dually eligible for Medicare and Medicaid experience high-quality, fully integrated care. In Ohio, individuals who are dually eligible are required to select a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) for their Medicaid coverage from among four contracted plans, while retaining the ability to select any Medicare plan. This structure underscores the importance of clear, accurate information and coordinated oversight to support informed decision-making and meaningful integration.

### **Improve State Oversight of D-SNPs**

We strongly support CMS's proposed changes to strengthen state oversight of D-SNPs. States are essential partners in monitoring D-SNP activities and ensuring enrollees have timely access to appropriate, high-quality care.

Specifically, we support CMS's proposal to codify a pathway for terminating D-SNP contracts when a plan fails to comply with state Medicaid agency requirements. This authority is a critical enforcement tool that enables states to protect beneficiaries and uphold program standards.

We also strongly support the proposal to require D-SNPs and other entities to submit marketing and enrollee materials through the CMS portal in a manner that allows for state review. State review and oversight of these materials is essential to ensuring accuracy, alignment with state-specific integrated care models, and compliance with beneficiary protections.

In Ohio, state oversight has played an important role in monitoring marketing practices, addressing enrollee access to care issues, and ensuring that materials accurately reflect programs such as Next Generation MyCare Ohio and the state's fully integrated D-SNP requirements. These proposed enhancements would further strengthen states' ability to act proactively to protect beneficiaries and support meaningful, high-quality integration for dually eligible individuals.

### **Retain Notice to Enrollees about Available Supplemental Benefits**

We oppose CMS's proposal to rescind the requirement for Medicare Advantage plans to provide a mid-year notice to enrollees about unused supplemental benefits. This notice is a simple, low-cost, and consumer-focused tool that would help ensure beneficiaries are aware of and able to access benefits they are already eligible for, such as vision, dental, transportation, meals, or in-home supports.

As our members work with older adults and Medicare beneficiaries, they often encounter individuals who are unaware that these supplemental benefits exist, misunderstand eligibility rules, or assume benefits are no longer available once they go unused earlier in the year—resulting in forgone care and unmet needs.

Eliminating the notice undermines beneficiary access, informed choice, and the value of supplemental benefits themselves. CMS should move forward with implementation of the mid-year unused supplemental benefits notice to promote transparency, improve benefit utilization, and better support the health and independence of Medicare Advantage enrollees.

### **Protect Access to Services and Quality Improvement**

We strongly oppose CMS's proposal to remove explicit references to populations that have historically faced discrimination and barriers to accessing Medicare Advantage services and to rescind the requirement that quality improvement programs address health disparities. Naming specific groups—such as people with disabilities, LGBTQI individuals, racial and ethnic minorities, rural residents, and those affected by persistent poverty provides necessary clarity, accountability, and direction to plans to ensure equitable access to care.

Eliminating the requirement that quality improvement programs include disparity-reduction activities weakens CMS's ability to advance health equity and undermines efforts to improve outcomes for populations at greatest risk. CMS should retain these provisions to protect access, promote accountability, and ensure Medicare Advantage serves all enrollees fairly and effectively.