January 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–4212–P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS–4212–P)

Submitted electronically: https://www.regulations.gov/commenton/CMS-2025-1393-0002

Dear Administrator Oz:

I write to you on behalf of the National Association of Social Workers (NASW). NASW is the largest membership organization of professional social workers in the world, with chapters covering all 50 states and the DC metropolitan area, Guam, Puerto Rico, and the U.S. Virgin Islands. The association promotes, develops, and protects the practice of social work and professional social workers. Social workers are the largest provider of mental, behavioral, and social care services in the nation and serve a crucial role in connecting individuals and families to health care services.

NASW appreciates the opportunity to submit comments on CMS–4212–P, notice of proposed rulemaking (NPRM) addressing Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. As an association, we have long advocated for an equitable health care system that helps Medicare beneficiaries by enhancing health care quality, decreasing out-of-pocket costs, and improving health care outcomes.

NASW's comments address the following subjects:

- Strengthening Current Medicare Advantage and Medicare Prescription Drug Program Policies (Operational Changes) (Section IV)
    - Special Enrollment Period for Provider Terminations (Section IV.A)

- Updating Third-Party Marketing Organizations (TPMOs) Disclaimer Requirements (Section IV.E)
- Removing Rules on Time and Manner of Beneficiary Outreach (Section IV.F)
- Relaxing the Restrictions on Language in Advertising (Section IV.G)
- TPMO Oversight: Revising the Record Retention Requirements for Marketing and Sales Call Recordings (Section IV.H)
- Rescinding the Requirement for the Notice of Availability (Section IV.I)

- Medicare Advantage/Part C and Part D Drug Plan Quality Rating System (Star Ratings) (Section V)
  - Removing Measures: Call Center—Foreign Language Interpreter and TTY Availability (Section V.B.1.c)
  - Adding Measure: Depression Screening and Follow-Up (Section V.B.2.a)
  - Additional Recommended Measures— Initiation and Engagement of Substance Use Disorder (SUD) Treatment; Network Adequacy Measure

- Improvements for Special Needs Plans (SNPs) (Section VI)
  - Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a Dual Eligible Special Needs Plan (D-SNP) and Medicaid Fee-for-Service (FFS) (Section VI.C)
  - Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination (Section VI.D)
  - Limitations on D-SNP-Only Contracts Submitting Materials under the Multicontract Entity Process (Section VI.E)

- Reducing Regulatory Burden and Costs in Accordance with Executive Order 14192 (Section VII)
  - Revisions to Ensuring Equitable Access to Medicare Advantage Services (Section VII.D)
  - Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (Section VII.E)

- Rescinding the Quality Improvement Program Health Disparities Requirement (Section VII.F)

- RFI—Future Directions in Medicare Advantage: Well-Being and Nutrition (Section VIII.D)

Our comments follow.

Strengthening Current Medicare Advantage and Medicare Prescription Drug Program Policies (Operational Changes) (Section IV)

Special Enrollment Period for Provider Terminations (Section IV.A)

NASW supports CMS's proposal to change the current special enrollment period (SEP) for Significant Change in Provider Network to an SEP for Provider Terminations. As CMS has noted in the proposed rule, some provider changes may not be considered "significant" for the majority of beneficiaries, but they may be significant for some enrollees. This can be especially true if the provider is a mental health or substance use disorder (SUD) provider, with whom trust and a therapeutic relationship has been built.

Updating Third-Party Marketing Organizations (TPMOs) Disclaimer Requirements (Section IV.E)

NASW strongly opposes CMS's proposal to remove SHIPs as a source of information from the standardized disclaimer conveyed by TPMOs (with whom MA organizations and Part D sponsors do business, directly or indirectly) during sales calls with Medicare beneficiaries. As stated in the NPRM, SHIP personnel—both paid and voluntary—are a source of unbiased information about plan choices. This neutrality contrasts with the steering toward MA frequently employed by plans, agents, and brokers (Bers, 2025, Fuglesten Biniek et al., 2023; Medicare Rights Center, 2025a). Experts from the University of Southern California (USC) have observed:

> The SHIP program combats misleading Medicare advertising and deceptive brokers by connecting eligible Americans with counselors by phone or in person to help them choose plans. Many people say they prefer meeting in person with a counselor over phone or internet support. SHIP staff say they often help people understand what's in Medicare Advantage ads and disenroll from plans they were directed to by brokers. (McCormack & Garrido, 2024, "Help is out there" section, para. 2; hyperlinks in original)

The availability of neutral, unbiased counseling is especially important given two factors:

- the August 2025 decision in the consolidated cases *Americans for Beneficiary Choice et al. v. United States Department of Health and Human Services* [HHS] *et al.* and *Council for Medicare Choice v. HHS et al.* (2025), which vacated key provisions of a 2024 CMS rule to rein in MA marketing misconduct (see also Bers, 2025)
- the decision by numerous large Medicare Advantage and Part D carriers to stop paying commissions to agents and brokers for enrolling Medicare beneficiaries "in many, or in some cases, all, of their Medicare Advantage and standalone Part D plans" (Lambert, 2025, Broker commission confusion section), which has resulted in beneficiaries being steered

> toward plans that would benefit agents and brokers (Lambert, 2025; see also C. Herman, 2025, "Changes to commissions" section)

Moreover, SHIP counselors can provide in-depth service with local context—qualities unmatched by 1-800-MEDICARE, the call center's value notwithstanding. In a recent article published by Georgetown University, for example, three SHIP counselors described spending up to an hour with each beneficiary to address complex coverage questions and underscored the value of each SHIP's local focus:

> Counselors are based in a local county program office. As a result, we know the landscape of our community: the MA and Part D plans that operate there, the prominent hospitals and physician groups in the area, and other health, social and other resources provided by the county. That level of help cannot be provided by Medicare's call center. (Hoadley et al., 2025, para. 11)

Similarly, KFF recently stated:

> 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. (Cottrill et al., 2025)

Thus, although NASW continues to encourage social workers to refer beneficiaries to 1-800-MEDICARE, we agree with an assertion by the Medicare Rights Center (MRC) that SHIPS "are often the only source of objective, one-on-one counseling available to help beneficiaries find the coverage that best meets their needs" (MRC, 2025b, p. 7).

Likewise, NASW concurs with MRC (Carter, 2025b) and other beneficiary advocacy organizations that SHIPs have long been underfunded—a pattern documented by the nonpartisan Congressional Research Service (Colello, 2023) and reiterated recently by KFF (Cottrill et al., 2025). More robust funding is essential to expand SHIPs' capacity.

Thus, NASW exhorts CMS to withdraw its proposal to remove SHIPs within 42 C.F.R. 422.2267(e)(41) and 423.2267(e)(41). Furthermore, we urge HHS to work with Congress to provide more robust funding for SHIPs.

Removing Rules on Time and Manner of Beneficiary Outreach (Section IV.F)

NASW opposes CMS's proposal to allow marketing events to occur after educational events in the same location. Separation of educational activities and sales activities, as required by current regulation, reduces pressure to enroll and

promotes informed decision making among beneficiaries. This is important even when beneficiaries attend educational and marketing events with a care partner; care partners themselves are often confused and overwhelmed by Medicare coverage options, especially given the proliferation of MA advertising. Moreover, we disagree that a Special Enrollment Period (SEP) is an adequate solution when a beneficiary enrolls in an MA plan as a result of misleading information provided by a plan sponsor. Such an SEP can be difficult to obtain; beneficiaries and care partners may be too overwhelmed to pursue an SEP, or they may not have records (such as an agent name or event date) to support their request.

Thus, NASW urges CMS to retain the current text at 42 C.F.R. 422.2264(c), 422.2274(b), 422.2274(c), 423.2264(c), 423.2274(b), and 423.2274(c)(9)(ii).

Relaxing the Restrictions on Language in Advertising (Section IV.G)
NASW strongly opposes CMS's proposal to relax regulations governing plan advertising, including the proposal to delete the current regulatory prohibition on providing inaccurate or misleading information and on using superlatives. Beneficiaries who enroll in an MA plan because of such information and language may experience decreased access and choice. For example, lack of information regarding prior authorization requirements can restrict beneficiary access to care. Inaccurate information about plan networks can result in beneficiaries' losing access to their chosen health care practitioners and facility providers. Thus, NASW urges CMS to retain the current text at 42 C.F.R. 422.2262(a)(1)(i), 422.2262(a)(1)(ii), 422.2262(a)(1)(ii)(A), 422.2262(a)(1)(i), 423.2262(a)(1)(ii), and 423.2262(a)(1)(ii)(A).

TPMO Oversight: Revising the Record Retention Requirements for Marketing and Sales Call Recordings (Section IV.H)
NASW opposes CMS's proposal to shorten the time a TPMO must retain audio records of its calls on behalf of MA organizations (MAOs). Likewise, we oppose CMS's proposal to delete regulations specifying requirements that TPMOs keep audio recordings of enrollment calls. Recordings of all TPMO calls—including, but not limited to, enrollment calls—constitute an integral source of accountability for TPMOs and MAOs. Such accountability is integral to beneficiary self-determination, as explained in our preceding comments. Furthermore, transcriptions are frequently inaccurate. Thus, we urge CMS to withdraw its proposals to revise the marketing and sales recording requirements at 42 C.F.R. 422.2274(g)(2) and 423.2274(g)(2).

Rescinding the Requirement for the Notice of Availability (Section IV.I)
NASW strongly opposes CMS's proposal to rescind regulations that specify the manner in which prescription drug plans (PDPs) and MA plans must notify enrollees of the availability of free language assistance services (such as interpretation in Spanish or American Sign Language) and auxiliary aids and

services. We recognize that MA and PDP plans would still be required to provide a Notice of Availability (NoA) under the Section 1557 nondiscrimination regulations (45 C.F.R. 92.11(a)) associated with the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). However, those rules are not specific to Medicare, and they require plans to provide the NoA only in the top 15 languages that are the primary language of at least 5 percent of individuals in the plan service area. This limited scope may mean that some beneficiaries would not receive an NoA in their primary language. Thus, NASW urges CMS to retain the requirement for plans to provide an NoA in all the required documents and languages specified in 42 C.F.R. 422.2267(e)(31) and 423.2267(e)(33).

Medicare Advantage/Part C and Part D Drug Plan Quality Rating System (Star Ratings) (Section V)

Removing Measures: Call Center—Foreign Language Interpreter and TTY Availability (Section V.B.1.c)

NASW opposes CMS's proposal to remove quality metrics addressing the extent to which beneficiaries are provided with the required language interpretation, including Deaf communication access. Language access is a foundational component of health care quality. The fact that plans tend to perform well on these measures does not negate the importance of them. We urge CMS to retain these quality measures.

Adding Measure: Depression Screening and Follow-Up (Section V.B.2.a)

NASW strongly supports CMS's proposal to add the "Depression Screening and Follow-Up" measure to the Star Ratings program beginning with the 2027 measurement year. Screening is important for older adults, in whom depression tends to be underdiagnosed and undertreated and for whom suicide risk is high. It is also important for younger Medicare beneficiaries who live with disabilities, given that depression frequently co-occurs with chronic conditions.

Follow-up care for beneficiaries with a positive screen for depression is essential, and the 30-day follow-up time frame is appropriate. NASW recommends that CMS provide clear guidance regarding the phrase "appropriate follow-up care." Services to consider, for example, include in-person or telehealth appointments with qualified mental health practitioners, including clinical social workers (CSWs); evidence-based psychotherapy; medication management by psychiatrists and other mental health professionals with prescribing privileges; and care coordination and referrals to additional services, such as services for substance use disorder (SUD) and home- and community-based social services. We urge CMS to ensure that follow-up care delivered using telehealth is counted toward measure performance; in-person appointments are often difficult, if not

impossible, for beneficiaries because of geography, limited mobility, and lack of transportation.

Moreover, MA plans must have sufficient mental health professionals—including clinical social workers—to provide follow-up care for beneficiaries with positive depression screens. Yet, many MA plans have not only inaccurate listings and limited provider networks, but also "ghost" or "phantom" providers—that is, inactive providers who do not provide services to plan enrollees (Lipschutz, 2025; Rae et al., 2025). Inclusion of these inactive providers can result in "ghost networks," "where plans hide the small number of in-network providers by including inactive providers" (Carter, 2025a). In fact, a recent HHS report (OIG, 2025) found that, on average, 55 percent of MA plans' network behavioral health providers were inactive. NASW exhorts CMS to address this problem by strengthening network adequacy requirements for MA plans.

Furthermore, NASW urges CMS to track depression screening and follow-up rates by demographic factors (including disability, ethnicity, gender, gender identity, geography, race, and sexual orientation). Such monitoring will enable CMS to identify and mitigate disparities in access to mental health care.

Additional Recommended Quality Measures

- Initiation and Engagement of SUD Treatment

NASW strongly encourages CMS to add the "Initiation and Engagement of SUD Treatment" (IET) to the MA star ratings program, as had been proposed in the MA proposed rule for contract year 2026 (Contract Year 2026 Policy and Technical Changes to Medicare Advantage, Part D, Medicare Cost Plan, and PACE, 2024). Similar to the Depression Screening and Follow-Up measure, IET is nationally endorsed and aligns with the private sector. As CMS noted in in the physician fee schedule NPRM for calendar year (CY) 2026, substance use is a risk factor for decreased prevention and management of chronic disease—a high priority for this administration (CY 2026 Medicare Physician Fee Schedule, 2025). Moreover, as CMS explained in the contract year 2026 NPRM, MA plans have been collecting these data for more than a decade (Contract Year 2026 Medicare Advantage and Part D, 2025). Thus, adding the IET measure to the MA Star Ratings program would not increase burden for plans. It would, however, incentivize MA plans to invest appropriately in and reduce barriers to SUD treatment.

- Network Adequacy Measure

NASW recommends that CMS adopt a quality measure for the MA Star Ratings system that includes the results of "secret shopper" surveys (which we address in greater detail in our comments on Section VIII). This composite measure should include two components: (1) the extent to which the MA plan's network is adequate (to mitigate ghost networks) and (2) the ability to schedule an

appointment. This measure would fill a critical gap in the current Star Ratings system and would promote beneficiaries' informed decision making regarding Medicare coverage.

Improvements for Special Needs Plans (SNPs) (Section VI)

Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a Dual Eligible Special Needs Plan (D-SNP) and Medicaid Fee-for-Service (FFS) (Section VI.C)

NASW commends CMS's efforts to improve service to beneficiaries who are dually eligible for Medicare and Medicaid. We support the proposal to require D-SNPs to engage in additional care coordination activities for D-SNP and Medicaid FFS enrollees and to report those activities to CMS. Implementation of this requirement would increase the likelihood that all dually eligible beneficiaries experience high-quality integration. For example, dually eligible beneficiaries in Medicaid FFS would benefit from assistance in accessing Medicaid services, filing Medicaid appeals, accessing transportation, and navigating care transitions from hospital to home and nursing facility to home. Thus, we support the proposed changes to 42 C.F.R. 422.107(d)(1)(i) and 422.514(h)(3).

Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination (Section VI.D)

NASW appreciates CMS's efforts to improve state oversight of D-SNPs. We strongly support codification of a pathway for terminating a D-SNP requirement that is not in compliance with state requirements. For example, a state may have requirements pertaining to marketing and beneficiary access to care. Thus, we support the proposed changes to 42 C.F.R. 422.510.

Limitations on D-SNP-Only Contracts Submitting Materials under the Multicontract Entity Process (Section VI.E)

NASW supports CMS's proposal to require D-SNPs and other entities to submit materials to a CMS portal in a manner that allows states to review those materials. Implementation of this proposal would enable states to monitor the activities of D-SNPs and act if a D-SNP does not provide adequate access to care. Thus, we support the proposed changes to 42 C.F.R. 422.2261(a) and 423.2261(a).

Request for Information (RFI): C-SNP and I-SNP Growth and Dually Eligible Individuals (Section VI.F.4)

NASW affirms CMS's interest in enhancing D-NP services for beneficiaries with mental health conditions (especially serious mental illness, or SMI) and SUDs. Dually eligible beneficiaries often experience significant barriers to coordinated care, resulting in poor health outcomes and increased program costs. Thus, we

support CMS's proposal to amend 42 C.F.R. 422.60(g)(2)(i) and (ii) to require that an integrated D-SNP receiving passive enrollment provide a continuity of care to all incoming enrollees for 120 days. Likewise, we strongly support CMS's proposal to amend § 422.60(g)(2)(vi) to specify that an integrated D-SNP receiving passive enrollment must have the care coordinator staffing capacity to receive dually eligible enrollees through passive enrollment. We recommend that CMS add the following requirements to realize the goals of these two amendments:

- Require D-SNPs that serve beneficiaries with SMI to include CSWs in care coordination teams.
- Establish and enforce provider network adequacy standards that ensure sufficient access to CSWs and other mental health practitioners across geographic areas.
- Require D-SNPs to adopt evidence-based integrated care models.
- Develop and monitor quality measures for D-SNP enrollees with SMI. Examples of such measures include appointment wait times and utilization rates for mental health and SUD services, medication adherence, housing stability, follow-up after psychiatric emergency department (ED) visits or hospitalization, and reduction in preventable ED use and hospitalizations.

Moreover, we urge CMS to require MA plans that serve a majority of dually eligible individuals to comply with the bipartisan Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (P.L. 110-343). A recent study found that dually eligible beneficiaries enrolled in MA plans receive lower quality care for opioid use disorder (OUD)—as measured by rate of OUD treatment initiation, OUD treatment engagement, and OUD medication access—not only than beneficiaries enrolled in FFS Medicare, but also than individuals enrolled only in Medicaid (Mark et al., 2025).

NASW recognizes that these disparities result, in part, because of the Medicare program's insufficient coverage of SUD treatment. These limitations notwithstanding, the ongoing opioid public health emergency (Administration for Strategic Preparedness and Response, 2025) warrants greater attention to OUD treatment by MA plans. Although MA and Part D plans are not required to adhere to MHPAEA, Medicaid managed care plans are subject to the law. Thus, dually eligible beneficiaries who are enrolled in those plans have greater access to OUD coverage than do dually eligible beneficiaries enrolled in MA and Part D plans. Consequently, we urge CMS to require plans that serve a majority of dually eligible beneficiaries to comply with MHPAEA.

Reducing Regulatory Burden and Costs in Accordance with Executive Order 14192 (Section VII)

Rescind Midyear Supplemental Benefits Notice (Section VII.C)

NASW opposes CMS's proposal to rescind the requirement for MA plans to send to each enrollee a midyear notice regarding the availability of unused supplemental benefits for which the enrollee is eligible. MA supplemental benefits are a key draw for beneficiaries; yet, many people enrolled in MA plans don't understand benefit eligibility and, consequently, underutilize supplemental benefits (Gershon & Carter, 2025; Kertesz, 2025). Thus, NASW urges CMS to retain the requirements in 42 C.F.R. 422.111(l) and 422.2267(e)(42).

Revisions to Ensuring Equitable Access to Medicare Advantage Services (Section VII.D)

NASW strongly opposes CMS's proposal to remove the requirement that MAOs provide culturally competent services to enrollees in the following groups:

- people of ethnic, cultural, racial, or religious minorities
- people with disabilities
- members of the LGBTQI community
- individuals in rural areas and areas with high levels of deprivation
- people affected by persistent poverty or inequality (42 C.F.R. 422.112(a)(8))

CMS's proposed wording—"Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds" (NPRM, p. 54988)—is insufficient. The wording in § 422.112(a)(8)) was expanded precisely because the terms "diverse" and "culture" have numerous connotations. Without such requirements, groups that have historically experienced discrimination in accessing Medicare services will experience worse health outcomes, resulting in increased long-term costs for the Medicare program. NASW exhorts CMS to retain the current regulation.

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (Section VII.E)

NASW strongly opposes CMS's proposal to delete the requirement that each MA plan publish an analysis of its prior authorization activities, including data on how prior authorization affects people with disabilities and other demographic groups. The impact of MA prior authorization on health care access has been well documented (see, for example, Fuglesten Biniek et al., 2025; Office of Inspector General, 2022; Rae et al., 2025; Ross & B. Herman, 2023). Without public reports on prior authorization, Medicare beneficiaries will have difficulty identifying the track record of any given MA plan. Thus, NASW urges CMS to retain the current language of 42 C.F.R. 422.137(c)(5), 422.137(d)(6), and 422.137(d)(7).

Rescinding the Quality Improvement Program Health Disparities Requirement (Section VII.F)

NASW strongly opposes CMS's proposal to delete the health disparities requirement within the MA quality improvement program for the reasons outlined in our comments on Section VII.D. Equitable access to health care services is essential to healthy communities and a healthy economy. Thus, NASW urges CMS to retain the current language in 42 C.F.R. 422.152(a)(5).

RFI—Future Directions in Medicare Advantage: Well-Being and Nutrition (Section VIII.D)

NASW appreciates the opportunity to suggest MA policy changes that would enhance the well-being of MA enrollees. We offer three recommendations for CMS's consideration:

- Align MA and Medicare Cost Plan cost sharing for mental health and SUD services with Medicare FFS cost sharing, as CMS proposed in the MA proposed rule for contract year 2026. Access to affordable mental health and SUD treatment is vital to the emotional well-being and overall health of Medicare beneficiaries.
- Measure meaningful access to timely care by requiring MA plans to contract with third-party entities to perform secret shopper surveys on their network directories, consistent with the requirements for other CMS-regulated plans. The current proposed rule includes information about CMS's own use of secret shopper surveys (in which third parties contacted SHIPs posing as dually eligible beneficiaries), reinforcing that this method is the industry standard for collecting valuable data on access to information and care. Moreover, adopting this requirement for MA plans would promote greater consistency across publicly funded insurance plans.
- Apply mental health and SUD parity protections to MA and Part D plans and remove barriers to treatment, including barriers to OUD medication access. Although MHPAEA was enacted to prevent discrimination in health insurance coverage, Medicare is not subject to the law. Thus, millions of people across the United States lose consumer protections when they become eligible for Medicare. We urge CMS to adopt, to the extent feasible, policies and practices that facilitate greater parity between mental health and SUD coverage and coverage for medical and surgical care. For example, CMS could remove unnecessary treatment limitations by requiring all MA and Part D plans to remove cost sharing, prior authorization, step therapy, and dosage caps (quantity limits) for OUD medications.

NASW refers CMS to comments submitted by the Legal Action Center for additional information regarding the three preceding recommendations.

Furthermore, we support the following policy changes offered by the Medicare Mental Health Workforce Coalition (of which NASW is a member):

- Improve MA enrollee access to mental health and SUD practitioners by addressing inequitable reimbursement rates. CSWs, mental health counselors, and marriage and family therapists continue to be reimbursed at lower rates than other practitioners of a similar level. This inequity discourages provider participation in Medicare. We encourage CMS to work with Congress to mitigate these inequities.
- Maintain telehealth flexibilities for mental health services provided to MA enrollees.
- Strengthen requirements for MA plans to maintain accurate, up-to-date directories, particularly for mental health and SUD providers; impose meaningful penalties for noncompliance.
- Systematically monitor and address disparities (related to disability, ethnicity, geography, and race) in mental health and SUD access and outcomes among MA enrollees. NASW recommends that gender, gender identity, and sexual orientation be added to this list.
- Clarify the continued applicability of the Outpatient Behavioral Health facility specialty type; establish corresponding data collection and network adequacy standards.

Thank you for your consideration of NASW's comments on this NPRM. Please do not hesitate to contact me at bbedney.nasw@socialworkers.org if you have questions.

Sincerely,

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