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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 22, 2026

TO: All Medicare Advantage Organizations, Section 1876 Cost Plans, and Stakeholders

FROM: Gerard J. Mulcahy
Acting Director

SUBJECT: Final Contract Year 2027 Standards for Part C Benefits, Bid Review and Evaluation

This memorandum includes final bid and operational instructions for Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans. Statutory cites in this memo are to the Social Security Act (the Act) and regulatory cites are to 42 C.F.R. parts 417 and 422 unless otherwise noted. This final memorandum applies only to Contract Year (CY) 2027 and applies standards in regulation applicable to CY 2027.

On February 23, 2026, CMS issued a preliminary HPMS memorandum to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2027 (HPMS memorandum titled, "Preliminary Contract Year 2027 Standards for Part C Benefits, Bid Review and Evaluation"). In the preliminary memorandum, CMS detailed how the CY 2027 Maximum Out-of-Pocket (MOOP) and cost-sharing limits and Total Beneficiary Cost (TBC) thresholds were developed in accordance with §§ 422.100(f) and (j), 422.101(d), 422.254(a)(4), and 422.256(a). CMS received comments from five organizations in response.

Comments regarding Dual Eligible Contract and Enrollment Requirements, Enrollment Capacity Limits, Total Beneficiary Cost (TBC), and Part C Maximum Out-of-Pocket Limits & Cost-Sharing Standards Overview are summarized and addressed in detail within the corresponding sections of this memorandum. After consideration of the comments received, CMS is finalizing the CY 2027 policies as discussed in this memorandum.

CMS includes administrative information regarding the TBC calculation, benefit policies and updates to the plan benefit package module as an appendix to this document (rather than a separate HPMS memorandum).

CMS annually evaluates available Medicare data and other information to apply MA program requirements in accordance with applicable law (for example, §§ 422.100(f) and (j), 422.101, and 422.256). MA organizations are afforded the flexibility to design their benefit packages so long as they satisfy Medicare coverage requirements.

Overview of CY 2027 Part C Benefits Review

Portions of this memorandum apply to Section 1876 Cost Plans as well as MA plans (including Employer Group Waiver Plans (EGWPs), Dual-Eligible Special Needs Plans (D-SNPs), Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

CMS provides tools and information to MA organizations in advance of the bid submission deadline and, therefore, expects all MA organizations to submit their best accurate and complete bid(s) on or before Monday, June 1, 2026, at 11:59 PM Pacific Time. Any organization whose bid fails the Part C Service Category Cost Sharing, per member per month (PMPM) Actuarial Equivalent Cost Sharing, Total Beneficiary Cost (TBC), and/or Optional Supplemental Benefit requirements and evaluation standards at any time prior to final approval may receive a compliance notice, even if the organization is allowed to correct the deficiency. The severity of compliance notice may depend on the type and/or severity of error(s).

Table 1 displays key MA bid review criteria by plan type.

Table 1: Applicable Bid Review Criteria by Plan Type

Bid Review Criteria	Applies to MA Plans that are Non-EGWP, Non-Dual Eligible SNPs	Applies to Dual Eligible SNPs	Applies to Section 1876 Cost Plans	Applies to EGWP Plans[1]
Low Enrollment § 422.510(a)(4)(xv)	Yes	Yes	No	No
Total Beneficiary Cost Sec. 1854(a)(5)(C)(ii) of the Act; §§ 422.254(a)(4) and 422.256(a)	Yes	No	No	No
Part C Optional Supplemental Benefits §§ 422.100(f) and 422.102	Yes	Yes	No	No
Part C MOOP Limits §§ 422.100(f)(4) and (5) and 422.101(d)(2) and (3)	Yes	Yes	No	Yes
Service Category Cost Sharing §§ 417.454(e), 422.100(f), 422.100(j), and 422.113(b)	Yes	Yes	Yes[2]	Yes
PMPM Actuarial Equivalent Cost Sharing §§ 422.254(b)(4) and 422.100(f)(6), (f)(7), and (j)(2)	Yes	Yes	No	Yes

[1]Employer Group Waiver Plans (EGWP) exclusively enroll only members of group health plans sponsored by employers, labor organizations, and/or trustees of funds established by one or more employers or labor organizations to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations.

[2]Section 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration services including chemotherapy drugs and radiation therapy integral to the treatment regimen (including Part B rebatable drugs that are for chemotherapy), skilled nursing care, and renal dialysis services; in addition, cost plans must use Original Medicare cost sharing for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) (§ 417.454(e)). These and additional cost-sharing requirements apply to MA plans under section 1852(a)(1)(B) of the Act and § 422.100(f) and (j).

In this memorandum, CMS interprets and applies certain regulatory and statutory standards and provides additional information on topics related to CY 2027 bids. Consistent with prior years, MA organizations must also address other requirements in their bids, such as the medical loss ratio, and are expected to do so independently of our requirements for benefits and bid review. Therefore, CMS is not making specific adjustments or allowances for these changes in the benefits review requirements.

Plans with Low Enrollment

CMS notified MA organizations that operate non-SNP MA plans that have fewer than 500 enrollees and SNP plans that have fewer than 100 enrollees and have been in existence for three or more years as of March 2026 (three annual election periods) of CMS's decision not to renew these plans under § 422.510(a)(4)(xv). Consistent with prior years, plans with low enrollment operating in service areas that do not have a sufficient number of competing options of the same plan type (such that the low enrollment plan still represents a viable plan option for beneficiaries), as determined by CMS, did not receive this notification. Please note that § 422.514(a)-(c) is a minimum enrollment requirement that is applied at the contract level as part of the MA application process and is independent of the plan-level termination authority in § 422.510(a)(4)(xv).

Upon receipt of this notification, MA organizations either (1) confirmed each of the low enrollment plans identified by CMS will be eliminated or consolidated with another of the organization's plans for CY 2027, or (2) provided a justification to CMS for renewal. If CMS found that the low enrollment justification was insufficient, CMS instructed the organization to eliminate or consolidate the plan. If the MA organization fails to comply with the instructions, CMS will terminate the plan under § 422.510 effective for contract year 2027. Instructions and the timeframe for submitting justifications were provided in CMS's notification to the organization. These requirements do not apply to Section 1876 cost plans, EGWPs, or Medical Savings Account (MSA) plans.

CMS recognizes there may be certain factors, such as the specific populations served by and the geographic location of the plan that led to a plan's low enrollment. SNPs, for example, may justifiably have low enrollments because they focus on a subset of enrollees with certain medical conditions or status. CMS considers this information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. In addition, MA organizations must follow applicable regulations (including § 422.530) and instructions regarding procedures for renewal/non-renewal and consolidations with other plans. CMS will continue to evaluate whether an MA plan has sufficient enrollment to establish that it is a viable independent plan option on an annual basis.

Dual Eligible Contract and Enrollment Requirements

MA organizations that seek to offer D-SNPs for CY 2027 should ensure that the bids submitted are consistent with § 422.514(h). Beginning with CY 2027, an MA organization that meets certain criteria may only offer, or have a parent organization or share a parent organization with another MA organization that offers, one D-SNP for full-benefit dual eligible individuals. These criteria are that the MA organization (or its parent organization or any entity that shares the parent organization with the MA organization): (1) contracts with a State as a Medicaid managed care organization (MCO) and (2) enrolls full-benefit dual eligible individuals in the same service area. The only exceptions to these requirements are at § 422.514(h)(3), specifically:

- If the State Medicaid agency's contract(s) with the MA organization differentiates enrollment into D-SNPs by age group or to align enrollment in each D-SNP with the eligibility or benefit design used in the State's Medicaid managed care program(s), the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization may offer one or more additional D-SNPs for full-benefit dual eligible individuals in the same service area in accordance with the group (or groups) eligible for D-SNPs based on the provisions of the contract with the State Medicaid agency under § 422.107; or
- If the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization offers both HMO D-SNP(s) and PPO D-SNP(s), and one or more of the –
    - HMO D-SNP(s) is subject to § 422.514(h)(1), the PPO D-SNP(s) not subject to § 422.514(h)(1) may continue if they no longer accept new enrollment of full-benefit dual eligible individuals in the same service area as the plan (or plans) subject to § 422.514(h)(1).
    - PPO D-SNP(s) is subject to § 422.514(h)(1), the HMO D-SNP(s) not subject to § 422.514(h)(1) may continue if they no longer accept new enrollment of full-benefit dual eligible individuals in the same service area as the plan (or plans) subject to § 422.514(h)(1).
- If the MA organization subject to § 422.514(h)(1) holds a State Medicaid agency contract with a State that does not mandate enrollment in Medicaid managed care for all full-benefit dually eligible individuals and the State Medicaid agency contract allows, the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization may offer one or more additional D-SNPs for full-benefit dually eligible individuals who are enrolled in Medicaid fee-for-service; or
- If a U.S. Territory has not adopted Medicare Savings Programs, as defined in § 435.4, an MA organization operating in such U.S. Territory is exempt from § 422.514(h)(1)(i).

In addition, such D-SNPs that do not meet the exceptions at § 422.514(h)(3) must limit new enrollment in the D-SNP to individuals enrolled in, or in the process of enrolling in, the Medicaid MCO.

MA organizations whose bid submissions are not compliant with these provisions will be subject to having the D-SNP State Medicaid agency contract rejected by CMS and may need to withdraw a bid submission without the ability to update assumptions for any remaining bid submissions. MA organizations should therefore consider submitting necessary crosswalk exceptions per the applicable exceptions articulated at 42 CFR § 422.530 for any plans that are not compliant with these provisions at the time the crosswalk exception module is made

available, as an opportunity to crosswalk will not be given for this purpose after the crosswalk exception request deadline.

CMS received two comments related to this section. A commenter noted that historically the crosswalk exceptions module is not available until after bids are due, so they asked how plans are supposed to submit crosswalk exceptions at the time of bid submission. This commenter also asked CMS to clarify the crosswalk exceptions allowed for 2027 and whether there is the potential for some flexibility. Specifically, they asked whether crosswalk exceptions can be used to move full-benefit dual members across contracts in states that do not carve duals into Medicaid managed care, and, for states that do include duals into their Medicaid managed care program, whether partial-dual members can be moved across contracts.

To clarify, we have updated the final bid memo language above to indicate that plans should submit the crosswalk exception at the time the crosswalk exceptions module is made available. It would not be acceptable to submit a crosswalk exception to move full-benefit dually eligible members across contracts in a state that does not carve in dually eligible individuals to their Medicaid managed care program. The crosswalk exceptions specific to D-SNPs being permitted to crosswalk members across contracts are codified at 42 CFR § 422.530(c)(3) and (4). For states that do include dually eligible individuals in their Medicaid managed care program, it would only be acceptable to crosswalk partial-benefit dually eligible members across contracts for the D-SNP to comply with 42 CFR §§ 422.514(h) and 422.504(a)(20).

Another commenter stated that the preliminary version of this memorandum requires full-benefit D-SNPs to limit new enrollment to members either enrolled with or in the process of enrolling with the MA organization's aligned Medicaid managed care organization (MCO). They contend that this requirement aligns with the CY 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F) published in April 2024 (the CY 2025 Final Rule) and what is currently codified at 42 CFR § 422.514(h), but contradicts what was proposed related to states where Medicaid managed care is not mandatory (such as New York) from the Contract Year 2027 Medicare Advantage and Part D Proposed Rule (CMS-4212-P) published in November 2025 (the CY 2027 Proposed Rule). This commenter requested CMS either align the dual eligible contract and enrollment requirements in this final memorandum with the CY 2027 Proposed Rule approach or clarify how FFS Medicaid beneficiaries may be handled in 2027 if this final memorandum is issued prior to the release of the CY 2027 Medicare Advantage and Part D Final Rule (CMS-4212-F) (the CY 2027 Final Rule).

We do not believe a change in the bid memo language is necessary based on the release of the CY 2027 Final Rule prior to the release of this final memorandum. As noted above and in the preliminary bid memo, § 422.514(h)(3) sets forth exceptions to the enrollment limitations in § 422.514(h). These exceptions include those finalized as part of the CY 2027 Final Rule.

Enrollment Capacity Limit

Per § 1854(a)(1)(A)(iii) of the Act and 42 CFR § 422.254(c)(4) and (e)(1), MA organizations may submit an enrollment capacity limit (if any) as part of their bid submission for a specific plan. As such, CMS will consider a plan's capacity to accept new enrollees in the course of bid review. Requesting an enrollment capacity limit as part of the bid is optional.

MA organizations will be able to submit a proposed enrollment capacity limit, if applicable, for each plan benefit package (PBP) as part of the HPMS bid submission process (Navigation Path: Plan Bids > Bid Submission > CY 2027 > Manage Plans > Set-Up Plans). To establish an enrollment capacity limit for CY2027, MA organizations must also submit a PDF that includes a short narrative explaining the basis for the identified limit. The supporting documentation for the proposed enrollment capacity limit must be uploaded as part of the bid submission in the "Cost-Sharing Justification" section (Navigation Path: Plan Bids > Bid Submission > CY 2027 > Upload > Cost-Sharing Justification). MA organizations should use the naming convention ***Capacity_Limits_HXXXX-XXX-XX_MMDDYYYY*** so that the uploads for enrollment capacity limits are distinguishable from any other Cost-Sharing Justification uploads that are submitted. Bid pricing assumptions, including projected enrollment, cannot be modified once the initial bid is submitted. There is no option for Part D sponsors to submit an enrollment capacity limit.

CMS will only accept enrollment capacity limits at or above current enrollment as of June 1, 2026, for plans' CY 2027 planned service area. MA organizations may not disenroll existing members to reach a capacity limit. For this and other reasons discussed below, CMS encourages plans to consider projected enrollment growth between the timing of the bid submission and the start of the plan year on January 1, 2027, when identifying an enrollment capacity limit in their bid.

An MA organization that has not established an enrollment capacity limit through the bid submission process under 42 CFR § 422.254(c)(4) or (e)(1) may not restrict enrollment for capacity reasons unless it requests and receives an enrollment capacity limit through the process set forth in 42 CFR § 422.60(b). CMS will consider such requests only if the health and safety of beneficiaries is at risk per 42 CFR § 422.60(b)(3).

CMS received one comment that included multiple policy and operational questions. CMS thanks the commenter for these detailed questions, which we have summarized here into three subtopics: preparing the enrollment capacity submission, operationalizing the limit, and market implications pursuant to capacity limits.

First, the commenter asked for details around developing the enrollment capacity limit submission. They asked whether the June 1 enrollment baseline is measured at contract-PBP or contract-PBP-segment level. They asked if CMS will allow justified limits below June 1 enrollment due to factors such as service area reductions, changes to provider networks, or the introduction of a successor plan in that service area. They sought guidance for new plans where there is no June 2026 enrollment to serve as a potential limit minimum.

Plans that submit an enrollment capacity limit must do so as part of the plan benefit package, specifically at the contract-PBP-segment level as part of their HPMS bid submission. In the preliminary bid memo, CMS stated that it will only accept capacity limits at or above current enrollment as of June 1, 2026. Specifically, this is enrollment as of June 1, 2026, for the planned service area for the CY 2027 bid. Plans should have the data necessary to factor in planned service area reductions, introduction of a successor plan, and expected changes to provider networks. If there is no past enrollment data to set a baseline, new plans that would like to include an enrollment capacity limit in their bid should utilize their assumptions on their plan's

projected enrollment used in the Bid Pricing Tool to inform their proposed limit with narrative justification.

Furthermore, plans are encouraged to consider factoring in enrollment growth between June 1, 2026, and January 1, 2027, when considering an enrollment capacity limit. However, even taking projected growth into account, it is possible that a plan's enrollment in 2026 may exceed a CY 2027 capacity limit before the start of the Annual Election Period, prior to 2027, or at the beginning of the CY 2027 benefit year. CMS acceptance of a CY 2027 capacity limit submitted as part of a plan's bid is subject to the condition that the plan may not retroactively disenroll beneficiaries to reach that limit for CY 2027. Existing membership must remain in the plan unless beneficiaries make a different choice during a valid enrollment period or are involuntarily disenrolled based on circumstances described in 42 CFR § 422.74(b), which are due to things like a beneficiary's failure to pay premiums or losing entitlement to Medicare. The existence of an enrollment capacity limit does not allow plans to involuntarily disenroll beneficiaries. As a reminder, plans are not required to submit an enrollment capacity limit as part of their bid; it is optional.

Second, the commenter inquired about the process by which a plan with an enrollment capacity limit established through the bid submission process may start limiting enrollment once the enrollment capacity limit has been met. They asked whether CMS must determine whether an enrollment capacity limit has been exceeded prior to the plan beginning to limit enrollment, whether MA organizations may choose to enforce the capacity limit for only a portion of the year, and how to manage enrollment requests when the plan is nearing or at the enrollment capacity limit.

All plans must accept valid requests to enroll during all election periods unless an established enrollment capacity limit is exceeded for CY 2027. A plan with an established enrollment capacity limit must accept all valid enrollments in the order they are received until the capacity limit is reached.

Plans with an established enrollment capacity limit are responsible for determining whether enrollment has met that limit. When a plan is closed due to an enrollment capacity limit, the plan must remain closed to all prospective enrollees in accordance with applicable regulations and guidance until space becomes available through natural attrition. Plans may not choose whether to enforce the limit; an enrollment capacity limit submitted in the bid and accepted by CMS is for the duration of the given plan year and must be enforced throughout. Furthermore, plans cannot request to lift or increase an accepted capacity limit following the bid or during the plan year. Given that once a limit is accepted it will stay in effect for the plan year, CMS encourages plans to consider their options carefully before submitting an enrollment capacity limit.

If the plan's enrollment exceeds the enrollment capacity limit before the start of the Annual Enrollment Period (AEP) in October 2026, it may not accept AEP enrollments for 1/1/27 enrollment start date. However, the plan must accept election requests using other election periods with 2026 effective dates (with the last possible effective date 12/1/2026). If the plan's enrollment is below the enrollment capacity limit before or at any point during the AEP, it must accept valid enrollment requests in the order they are received until the limit is met.

Plans must monitor their enrollment data and should proceed cautiously when they are nearing their enrollment capacity limit to ensure they reach but do not exceed it. They will receive real-time responses from CMS for enrollment transactions submitted through MARx's user interface (UI) and Medicare Daily Transaction Reply Reports (DTRRs). Once a plan is nearing its enrollment capacity limit, it may need to break batches of enrollments into smaller units so as not to inadvertently exceed the enrollment capacity limit. If a plan has several enrollment forms from one day such that submitting them all would exceed its enrollment capacity limit, the plan needs to submit the earliest enrollments received in that day up to and including the enrollment capacity limit. If a plan, in the processing of enrollments in a given day, inadvertently exceeded its enrollment capacity limit, the plan may not disenroll those additional enrollments. If CMS accepts an enrollment capacity limit as part of the bid, CMS will share additional guidance with the plan on enrollment processes and address any remaining questions the plan may have.

Finally, the commenter noted concerns about the market-level effects that may result from enrollment capacity limits across plans within a service area. They noted that if some plans have enrollment capacity limits while other plans in the same service area do not, membership growth could be restricted to the plans without enrollment capacity limits, and they were concerned it might direct growth toward plans who are not prepared to absorb it. The commenter also flagged a scenario that if all plans in a given county reach their established enrollment capacity limits, beneficiaries seeking to enroll in an MA plan in that county could be left without any plan options. The commenter requested that CMS monitor and consider safeguards to mitigate these potential effects.

CMS thanks the commenter for flagging these concerns on the market implications of enrollment capacity limits and shares the goals of avoiding beneficiary harms and ensuring access to MA plans. Plans' ability to submit enrollment capacity limits as part of the bid is authorized by 1854(a)(1)(A)(iii) of the Act and 42 CFR § 422.254(c)(4) and (e)(1). CMS monitors the number of plans available to enrollees in all service areas on an ongoing basis and will consider adjusting the approach to reviewing and accepting these limits in future years.

Total Beneficiary Cost (TBC)

Under section 1854(a)(5)(C)(ii) of the Act, CMS is not obligated to accept every bid submitted and is authorized to deny a plan bid if it determines the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. In exercising this authority, CMS will use the same TBC evaluation as in past years to calculate the TBC change amount as described below. For 2027, the TBC evaluation will be consistent with the approach used for 2026. This includes using the same TBC change amount of $40.00 PMPM and applying the same methodology for plan-specific adjustments. In applying the TBC evaluation, plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s). MA organizations are strongly encouraged to use the available tools and TBC information in developing and preparing their bids.

A plan's TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes in the plan benefit

package (PBP) (i.e., cost-sharing changes) on plan enrollees; an increase in TBC is indicative of an increase to beneficiary costs or a reduction in benefits. By reviewing excessive increases in the TBC from one year to the next, CMS is able to keep the MA plan offerings reasonably stable from one year to the next and avoid significant increases in cost sharing or decreases in benefits.

Consistent with past years, CMS will use updated versions of the Part C and Part D Out-of-Pocket Cost (OOPC) Models to estimate beneficiary out-of-pocket costs in the TBC calculation for CY 2027 bid evaluation purposes. The Part C OOPC Model includes annual utilization updates based on the Medicare Current Beneficiary Survey (MCBS) results. CMS generated updated CY 2026 Part C and Part D Baseline OOPC Model values for organizations and posted these values in HPMS (see HPMS memorandum titled "Contract Year 2026 Part C and Part D Baseline Out-of-Pocket Cost Models" issued December 23, 2025). MA organizations can view their plan OOPC values in HPMS under: Quality and Performance > Performance Metrics > Reports > Costs > Part C Out-of-Pocket Costs. In addition, CMS released the CY 2027 Bid Review OOPC Models (see HPMS memorandum titled "Contract Year 2027 Bid Review Out-of-Pocket Cost (OOPC) Models" issued April 16, 2026). Note that CMS is also planning an annual refresh of the Part D Bid Review OOPC Model to reflect updates in the May Formulary Reference File (FRF) consistent with past years.

As in past years, for 2027, CMS will not evaluate TBC for EGWPs, MSA plans, D-SNPs, and Chronic Kidney Disease C-SNPs. EGWP benefit packages are negotiated arrangements between employer groups and MA organizations so we believe that the employer would have taken these costs into account in making such plans available. MSAs have unique benefit designs that include a medical savings account for purposes of paying for Part A and B benefits costs before the enrollee meets the deductible. D-SNP PBP data entry does not include the additional state benefits and cost-sharing relief that dually eligible beneficiaries will have in that plan. These factors prevent the TBC evaluation (that uses PBP data) from reflecting the full benefit and cost-sharing package available to enrollees in D-SNPs. Finally, Chronic Kidney Disease C-SNPs are not effectively addressed by the OOPC model used for the TBC evaluation because the OOPC model cohort includes beneficiaries with and without ESRD and these plans potentially experience larger increases and/or decreases in payment amounts. These ESRD C-SNPs are subject to all other MA standards and CMS will contact plans if CMS identifies large benefit or premium changes (while taking into consideration payment changes) during bid review. Consistent with CY 2026, MA plans offering Part C supplemental benefits that take advantage of the flexibility in the uniformity requirements under § 422.100(d)(2)(ii), Special Supplemental Benefits for the Chronically Ill (SSBCI), will be subject to the TBC evaluation for CY 2027. However, the TBC calculation excludes benefits and cost-sharing reductions entered in the MA Uniformity and SSBCI sections of the PBP. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan.

Under §§ 422.254 and 422.256, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the given amount. This approach not only keeps MA plan cost sharing and benefit designs stable, but also ensures enrollees have access to viable and sustainable MA plan offerings.

CMS will continue to incorporate the technical and payment adjustments described below and expects organizations to address other factors, such as MA payment policy changes, independently of our TBC standard. As such, plans are expected to manage changes in payment

and other factors to minimize changes in MA plan benefits and cost sharing over time. CMS also reminds MA organizations that the OACT extends flexibility on gain/loss margin requirements so MA organizations can satisfy the TBC standard.

In the preliminary memorandum, CMS stated that, as in past years, CMS will provide plan specific CY 2027 TBC values and incorporate the following adjustments in the TBC calculation to account for changes from one year to the next:

- Technical Adjustments: (1) annual changes in OOPC model software and (2) maximum Part B premium buy-down amount change in the bid pricing tool ($202.90).[1]
- Payment Adjustments: (1) county benchmark, and (2) quality bonus payment and/or rebate percentages.

As discussed previously, the updated Part C and D OOPC Models are being used to evaluate year to year TBC changes with CY 2027 bid submissions. The unweighted average beneficiary cost for plans subject to the TBC evaluation, using the 2026 Baseline OOPC models, is about $408 PMPM, as illustrated in Table 2 below.

In the preliminary memorandum, CMS indicated that the TBC change threshold for the CY 2027 bid evaluation would be $40.00 PMPM. Consistent with application of the TBC evaluation, as discussed in the CY 2012 Final Call Letter,[2] CMS calculated the TBC change threshold for bid evaluation purposes at $40.00 PMPM or about 10% of the $408.25 Total Beneficiary Cost for the CY 2026 Updated Baseline OOPC Models in the table below.

In response to the preliminary memorandum, three commenters requested changes to the applicability, methodology, or TBC change threshold. Specifically, a commenter requested CMS exclude I-SNPs from the TBC test, similar to D-SNPs. This commenter stated that since most I-SNP enrollees are low-income or dual eligible, the current methodology does not accurately reflect their member experience. They noted that premium changes are less meaningful for this population and cited CMS data from a recent RFI which showed that about 91 percent (in 2025) of I-SNP enrollees are dual eligible. This commenter suggested that this recent CMS data essentially refutes CMS' prior rationale (included in last year's version of this memorandum, the Final Contract Year (CY) 2026 Standards for Part C Benefits, Bid Review and Evaluation, issued April 16, 2025) for continuing to apply the TBC evaluation to I-SNPs. For reference, that rationale was that the percentage of dual eligibles in I-SNPs varies widely and non-dually eligible beneficiaries are permitted to enroll in I-SNPs, thereby making the TBC evaluation an important protection for non-dually eligible enrollees in I-SNPs.
Based on this data, this commenter asked CMS to exempt I-SNPs from TBC for CY 2027, or at least exempt plans with a high share (>60%) of low-income enrollees.

We thank the commenter for the comment. We believe the commenter was referencing the 90.8 figure from Table FF4 (I-SNPs and their enrollment: CY 2021 – 2025) from the CY 2027

[1] The CY 2027 Part B premium buy-down is limited to the dollar amount of the CY 2026 Part B premium.
[2] See https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf, pages 128-129.

Proposed Rule[3]. Based on that table (which reflects IDR data) and our analysis of HPMS plan data, the overall average percentage of total I-SNP enrollment for dual eligibles has approximately ranged between (from CY 2021 through 2026) 86% - 91%. However, for this same time period, the distribution of those dual eligible enrollees in I-SNPs has varied. For example, for CY 2026 based on HPMS plan data, most plans (105 out of 156) have greater than 80% of their enrollment made up of dual eligibles and a small subset of plans (51 out of 156) have less than 80% of their enrollment made up of dual eligibles (most in that subset have between 0-17% dual eligible enrollment). This bimodal distribution of dual eligible enrollment in I-SNPs has remained consistent since CY 2021. Given this significant proportion of dual-eligible enrollees in most I-SNPs, CMS considered exempting I-SNP plans with a high share of dual eligible enrollees from the TBC evaluation. However, as non-dually eligible beneficiaries can still enroll in any I-SNP, we believe the TBC evaluation is beneficial to apply to all I-SNPs to protect this vulnerable population (institutionalized beneficiaries without the cost sharing protections afforded to those who are dual eligible). For this reason, CMS will maintain the TBC evaluation for I-SNPs.

Another commenter stated that the TBC methodology still fails to account for the funding effects associated with risk model impacts, specifically, the proposed 2027 CMS-HCC risk adjustment model updates. They stated that the risk model impacts affect plan revenue similarly to plan-specific adjustments for anticipated changes in benchmarks, projected bid growth, and Star Ratings, all of which are accounted for in the methodology. This commenter stated those funding effects materially affect bids and should either be incorporated into TBC adjustments through a global assumption (consistent with the global assumption CMS already makes for the growth in plan-level A/B bid amounts) or offset by a higher TBC threshold. They said that without this change the TBC evaluation may lead to plan exits and unintended member disruption.

Thank you for the comment. CMS appreciates the input received about the potential impact of risk adjustment and is considering updating the TBC methodology to account for risk model impacts for a future year as we need sufficient time to analyze the impact this could have on beneficiaries and plans. CMS will provide opportunity for public comment on any future changes to the TBC evaluation.

Two commenters requested CMS increase the CY 2027 TBC threshold. One of these commenters stated that CMS used an inconsistent rounding approach for the CY 2027 TBC threshold: since 10% of average TBC is $40.83, they said CMS should round up to $41 PMPM, consistent with prior years, rather than rounding down to $40. Another commenter requested that CMS increase the CY 2027 TBC change threshold from $40.00 to $60.00 PMPM. This commenter stated that this increase would give plans greater flexibility to adjust benefits and formularies given the expected MA +0.09% payment change (detailed in the Advance Notice) that they defined as well below trend and would require plans to reduce benefits up to or beyond the proposed $40.00 PMPM TBC change threshold.

We thank the commenters for the comments. As discussed in the preliminary version of this memorandum, CMS calculated the TBC change threshold for bid evaluation purposes at $40.00 PMPM or about 10% of the $408.25 Total Beneficiary Cost for the CY 2026 Updated Baseline

[3] This proposed rule may be accessed at: https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program

OOPC Models from Table 2 below. We did not round the TBC change threshold up to $41.00 because CMS aims to provide stability in the TBC evaluation year over year if possible. For CY 2027, we believe the 10% of average TBC ($40.83) is sufficiently close enough to $40 to align the TBC evaluation with the threshold from the last two contract years to avoid unnecessary fluctuations in the standard. In addition, CMS is concerned that an increase to $60.00 PMPM for the TBC threshold would not protect beneficiaries from significant increases in cost sharing or reductions in benefits from one year to the next. CMS has historically proposed the threshold at approximately 10% of the unweighted average TBC across all plans to protect beneficiaries from significant increases. An increase to $60.00 PMPM would be roughly equal to 14.7% of the unweighted average TBC for CY 2027. As such, we will not increase the CY 2027 TBC change threshold to that magnitude.

After considering these comments, CMS is finalizing a TBC change threshold for CY 2027 at $40.00. CMS has provided the tools necessary for MA organizations to plan for these changes and prepare their bids in a manner to satisfy the TBC evaluation. We note that the year-to-year change in the Part B premium amount is accounted for in the technical adjustments discussed previously.

Table 2: TBC Calculation Based on CY 2026 Baseline OOPC Model

(Unweighted Per Member Per Month Averages)

Item	2026 Baseline OOPC Models
Part C OOPC	$137.76
Part D OOPC	$86.65
Part B Premium	$163.78
Plan Premium (Parts C&D)	$20.06
Total Beneficiary Cost	**$408.25**

Plan bids with a TBC change amount greater than the thresholds discussed below will be further scrutinized on a case-by-case basis and CMS may request an MA organization provide a justification or change its bid(s) as part of bid negotiation. (See above for a discussion about which MA plans are not subject to the TBC evaluation and below for information about situation-specific adjustments.) CMS includes administrative information regarding the TBC calculation, benefit policies and updates to plan benefit package module as an appendix to this document (rather than a separate HPMS memorandum).

A plan experiencing a net increase in adjustments may have an effective TBC change amount below the $40.00 PMPM threshold. Conversely, a plan experiencing a net decrease in adjustments may have an effective TBC change amount above the $40.00 PMPM threshold. To support plans that received increased quality compensation and experience large payment adjustments, along with holding plans accountable for lower quality, CMS will apply the TBC evaluation for CY 2027 as follows:

- Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $40.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $40.00 PMPM) plus applicable technical adjustments.

- Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount less than -$40.00 PMPM will have a TBC change threshold of $80.00 PMPM (i.e., 2 times TBC change limit of $40.00 PMPM) plus applicable technical adjustments. That is, plans should not make changes that result in greater than $80.00 worth of decreased benefits or increased premiums.
- Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$40.00 PMPM will have a TBC change threshold of $80.00 PMPM (i.e., 2 times TBC change limit of $40.00) plus applicable technical adjustments.
- Plans not accounted for in the three specific situations above are evaluated at the $40.00 PMPM limit.

If CMS provides the MA organization an opportunity to address CY 2027 TBC issues following the bid submission deadline, the MA organization may not change its formulary (e.g., adding drugs, etc.) to satisfy this standard. The formulary review process has multiple stages and making changes that are unrelated to CMS-identified formulary review concerns negatively affects the formulary and bid review process. For example, portions of the annual formulary review process are based on outlier analyses. If an MA organization were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition, significant formulary changes will necessitate additional CMS review, outside of the normal review stages, and may jeopardize the approval of a sponsor's formulary and could affect approval of its contract.

CMS provides detailed TBC information and examples of how the TBC evaluation will be applied to consolidating or crosswalking plans in the appendix of this document.

Part C Optional Supplemental Benefits

CMS will review non-EGWP MA plans' bid submissions to verify that enrollees electing optional supplemental benefits are receiving reasonable value at the MA contract level. CMS considers plan designs for optional supplemental benefits to have a reasonable value when the total value of the optional supplemental benefits offered by all plans under the contract meet the following thresholds: (a) the enrollment weighted contract-level projected gain/loss margin, as measured by a percent of premium, is no greater than 15% and (b) the sum of the: (1) enrollment-weighted contract-level projected gain/loss margin and (2) non-benefit expenses, as measured by a percent of premium, is no greater than 30%. CMS understands some supplemental benefits are based on a multi-year projection, but the plan bids submitted each year are evaluated based on that plan year. MA plans that offer optional supplemental benefits are still subject to Part 422 regulations (e.g., uniformity requirements, appeals, reporting, etc.).

Part C Maximum Out-of-Pocket Limits & Cost-Sharing Standards Overview

Per §§ 422.100(f)(4) and (f)(5) and 422.101(d)(2) and (d)(3), MA plans must establish annual in-network and combined MOOP amount for all Parts A and B services that are no greater than the annual in-network and combined MOOP limits calculated by CMS. Per § 422.100(f)(6), 422.100(j)(1), and 422.113(b)(2), MA plans must also establish service category specific cost-sharing amounts for Parts A and B services that are no greater than the annual cost-sharing limits calculated by CMS for those services. Specifically, all MA plans must comply with the cost sharing and MOOP limits established using the methodologies in §§ 422.100(f) and (j) and

422.101(d) – except for MA MSA plans.[4] MA MSA plans must not cover basic benefits until the plan's deductible has been reached and after the deductible is reached, the MSA plan must cover 100 percent of the costs of basic benefits. See section 1859(b)(3) of the Act and § 422.4(a)(2). In addition to the MOOP and benefit category cost-sharing limits, MA plans must comply with the aggregate and service-category specific PMPM actuarially equivalent requirements (§ 422.100(j)(2)). MA EGWPs continue to be subject to all MA regulatory requirements that have not explicitly been waived by CMS, regardless of whether they are affirmatively evaluated as part of bid review or in connection with other reviews.

CMS followed the methodology in §§ 422.100(f) and (j), 422.101(d), and 422.113(b) to calculate the CY 2027 MOOP limits and cost-sharing standards included in this memorandum.

Per §§ 422.100(f)(4) and (f)(5) and 422.101(d)(2) and (d)(3), CMS calculated three in-network and combined MOOP limits using Medicare fee-for-service (FFS) data projections (as shown in Table 3). For each in-network MOOP type CMS also calculated corresponding in-network service category specific cost-sharing limits (as shown in Table 4). An organization that establishes a plan's MOOP amount within the dollar range specified by CMS for a particular MOOP limit has the corresponding mandatory, intermediate, or lower MOOP type. These MOOP types are as follows:

- Mandatory: Highest in-network MOOP amount allowed by CMS.
- Lower: Plans may voluntarily adopt this lower in-network MOOP amount established by CMS in exchange for increased flexibility in cost-sharing requirements.
- Intermediate: Mid-point option between lower and mandatory MOOP limits to encourage plans to adopt lower in-network MOOP amounts with some flexibility in cost-sharing requirements.
- Combined (Catastrophic): PPO plans must have a combined MOOP amount inclusive of in-and out-of-network cost sharing for all Parts A and B services per §§ 422.100(f)(5) and 422.101(d)(2) and (d)(3). Per § 422.101(d)(2)(ii), MA plans must have the same type of in-network and combined MOOP type.

The calculations supporting the CY 2027 MOOP and cost-sharing limits discussed in this memorandum (and the reference calculations for the CY 2024 - 2026 MOOP and cost-sharing limits) are available for review at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. In this memorandum and the related CY 2027 calculation files, we identify and, as necessary, explain substantive differences in calculating MOOP limits and cost-sharing standards compared to the methodology used for CY 2026 requirements. For example, CMS separated the prior service category "DME – diabetes monitoring supplies" into two separate service categories that group high (e.g., continuous and blood glucose monitors) and low (e.g., test strips, calibration solution, and lancet) costs together as described in the footnote to Table 4. The calculations CMS completed to set copayment limits for these categories are available in the

[4] Additional detail about the rules CMS follows to set the MOOP and cost-sharing limits is available in the final rule with comment period, "Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost-Sharing Standards", which appeared in the Federal Register on April 14, 2022, referred to as the April 2022 final rule. The April 2022 final rule is available at: https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards.

CY 2027 calculation file under the tabs named "DME Diabetic Supplies" and "DME Diabetic Monitors".

A commenter requested CMS clarify how MA organizations should file Continuous Glucose Monitor (CGM) sensors (like a test strip, replaced every 2 weeks) and transmitters (not typically replaced) given the new breakdown of "DME – diabetes monitoring supplies" into "DME diabetic supplies" and "DME diabetic monitors".

MA organizations should consider replaceable sensors as subject to the cost sharing limits for DME diabetic supplies, and transmitters (not typically replaced) as subject to the cost sharing limits for DME diabetic monitors.

The OACT used actuarial judgement consistent with § 422.100(f)(7) to select the year(s) of Medicare FFS data and to apply trend factors to develop CY 2027 Medicare FFS data projections (consistent with the most recent Medicare Trustees Report, President's Budget, and changes in statute, regulation, and payment policies). CMS used the CY 2027 Medicare FFS data projections to calculate the CY 2027 MOOP and cost-sharing limits. This approach remains consistent with the development of the CY 2026 Medicare FFS data projections used to set CY 2026 MOOP and cost-sharing limits. The year(s) of Medicare FFS data and trend factors that the OACT used to develop the CY 2027 Medicare FFS data projections are summarized in the footnotes of the CY 2027 calculation file.

Part C Maximum Out–of-Pocket Limits

CMS followed the methodology in § 422.100(f)(4), particularly paragraphs (f)(4)(v) and (f)(4)(vi)(B), and § 422.101(d)(2) and (d)(3) to calculate the CY 2027 MOOP limits. This involved basing calculations on Medicare FFS data projections[5] and applying the 10 percent cap on increases from the prior contract year to the in-network mandatory and lower MOOP types, if applicable. The CY 2027 Medicare FFS data projections, as rounded per § 422.100(f)(4)(iii), for the mandatory and lower MOOP limits did not exceed the 10 percent cap on increases. As a result, the CY 2027 in-network MOOP limits in Table 3 reflect the applicable projected Medicare FFS percentiles and the numeric midpoint for the intermediate MOOP type, application of the rounding rules, and 100 percent of ESRD costs.

MA plans must comply with the MOOP limits in Table 3 for CY 2027. Consistent with prior contract years, the PBP module includes validations to prevent an MA organization from entering MOOP and cost-sharing amounts that are above the MOOP and cost-sharing limits for the year, while also allowing plans to have MOOP and cost-sharing amounts that are not rounded to a whole dollar amount. For example, an HMO plan that establishes an in-network MOOP amount of $4,450.50 will be considered an intermediate MOOP based on PBP validations applied to that plan's data entry (i.e., $4,450.50 exceeds the $4,450 lower MOOP limit in Table 3).

[5] As defined in § 422.100(f)(4)(i), Medicare FFS data projections include data for beneficiaries with and without diagnoses of ESRD. Per § 422.100(f)(vi)(B), the CY 2026 MOOP limits reflect 100 percent of the ESRD cost differential.

TABLE 3: FINAL CY 2027 PART C MOOP LIMITS BY PLAN TYPE

Plan Type	Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
HMO and HMO POS	$0 to $4,450 In-network	$4,451 to $7,150 In-network	$7,151 to $9,850 In-network
PPO (Local and Regional)	$0 to $4,450 In-network and $0 to $6,700 Combined	$4,451 to $7,150 In-network and $4,451 to $10,750 Combined	$7,151 to $9,850 In-network and $7,151 to $14,800 Combined
PFFS (full, partial, and non-network)	$0 to $4,450	$4,451 to $7,150	$7,151 to $9,850

Cost-Sharing Standards

To calculate the CY 2027 inpatient hospital cost-sharing limits, CMS followed the methodology in § 422.100(f)(6)(ii)(B), (f)(6)(iv), and (f)(7). CMS used CY 2027 Medicare FFS data projections to calculate the inpatient hospital cost-sharing limits, but for the inpatient hospital acute 60-day length of stay scenario and lower MOOP type, the result exceeded the Part C lower MOOP amount. In this case, CMS capped the cost-sharing limit at the lower MOOP amount from Table 3.

To calculate the CY 2027 cost-sharing limits for professional services and service categories for which cost sharing must not exceed cost sharing under Original Medicare, CMS followed the methodology in § 422.100(f)(6)(iii), (f)(7), (f)(8), and (j)(1). Per § 422.100(f)(8), the copayment limits for 2027 for the service categories subject to § 422.100(f)(6)(iii) (professional services that are basic benefits) and § 422.100(j)(1) (basic benefits for which the cost sharing must not exceed Original Medicare cost sharing) are set at an amount that is an actuarially equivalent value to the applicable cost-sharing standard (from paragraph (f)(6)(iii) or (j)(1)).

On November 7, 2022, CMS issued an HPMS memorandum, "Inflation Reduction Act Changes to Cost Sharing for Part B Drugs for Contract Year 2023 Medicare Advantage and Section 1876 Cost Plans," to provide guidance for CY 2023 on the beneficiary cost-sharing protections under section 11101 (Part B drugs with prices increasing faster than inflation) and section 11407 (Monthly cost-sharing cap for insulins furnished under Part B benefit) of the Inflation Reduction Act (IRA, P.L. 117-169), enacted on August 16, 2022. The beneficiary cost-sharing protections from these IRA provisions are reflected in the appropriate categories of Part B drug cost-sharing limits in Table 4.

Table 4 below summarizes the standards and maximum permissible cost-sharing amounts by MOOP type under § 422.100(f)(6), (f)(7), (f)(8), (j)(1), and (o); CY 2027 bids must reflect enrollee cost sharing no greater than the amounts displayed below. These standards will be applied to in-network Parts A and B services and, per § 422.100(o), out-of-network Parts A and B services for D-SNP PPOs. All standards and cost sharing are inclusive of applicable service category deductibles, copayments, and coinsurance, but do not include plan level deductibles (for example, deductibles that include several service categories). Per § 422.100(f)(9), plan cost sharing (copayments and coinsurance) for basic benefits must reflect the enrollee's entire cost-sharing responsibility, inclusive of professional, facility, or provider setting charges, by combining (or bundling) all applicable fees into the cost-sharing amount for that particular

service(s) and setting(s) and be clearly reflected as a single, total cost sharing in appropriate materials distributed to beneficiaries for basic benefits.

TABLE 4: FINAL CY 2027 SERVICE CATEGORY COST-SHARING LIMITS (IN-NETWORK FOR ALL PLANS AND OUT-OF-NETWORK FOR D-SNP PPOs)

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
Inpatient Hospital – Acute – 60 days[1]	1a	$4,450	$5,259	$6,068
Inpatient Hospital – Acute – 10 days[1]	1a	$3,397	$3,058	$2,718
Inpatient Hospital – Acute – 6 days[1]	1a	$3,062	$2,756	$2,450
Inpatient Hospital – Acute – 3 days[1]	1a	$2,801	$2,521	$2,241
Inpatient Hospital Psychiatric – 60 days[1]	1b	$4,174	$3,756	$3,339
Inpatient Hospital Psychiatric – 15 days[1]	1b	$2,824	$2,541	$2,259
Inpatient Hospital Psychiatric – 8 days[1]	1b	$2,614	$2,352	$2,091
Skilled Nursing Facility – First 20 Days[3]	2	$20/day	$10/day	$0/day
Skilled Nursing Facility – Days 21 through 100[3]	2	$221/day	$221/day	$221/day
Cardiac Rehabilitation	3-1	50% / $55	40% / $40	30% / $30
Intensive Cardiac Rehabilitation	3-2	50% / $70	40% / $55	30% / $40
Pulmonary Rehabilitation	3-3	50% / $40	40% / $35	30% / $25
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)	3-4	50% / $30	40% / $25	30% /$20
Emergency Services[4]	4a	$150	$130	$115
Urgently Needed Services[4]	4b	50% / $65	40% / $50	30% / $40
Partial Hospitalization Program	5a	50% / $190	40% / $155	30% / $115
Intensive Outpatient Services	5b	50% / $200	40% / $160	30% / $120
Home Health[2]	6	20% / $55	$0	$0
Primary Care Physician	7a	50% / $70	40% / $55	30% / $40
Chiropractic Care	7b	50% / $20	40% / $15	30% / $15
Occupational Therapy	7c	50% / $60	40% / $50	30% / $35
Physician Specialist	7d	50% / $95	40% / $75	30% / $60
Mental Health Specialty Services	7e	50% / $85	40% / $65	30% / $50
Psychiatric Services	7h	50% / $90	40% / $75	30% / $55
Physical Therapy and Speech-language Pathology	7i	50% / $90	40% / $75	30% / $55
Therapeutic Radiological Services[2]	8b2	20% / $85	20% / $85	20% / $85
DME-Equipment	11a	50%	50%	20%[2]
DME-Prosthetics	11b1	50%	50%	20%[2]
DME-Medical Supplies	11b2	50%	50%	20%[2]
DME-Diabetic Supplies[5]	11c1	50% / $50	50% / $50	20% / $20[2]
DME-Diabetic Shoes or Inserts	11c2	50% / $30	50% / $30	20% / $10[2]
DME-Diabetic Monitors[5]	11c3	50% / $75	50% / $75	20% / $30
Dialysis Services[2]	12	20% / $70	20% / $70	20% / $70
Part B Drugs-Insulin[6]	15-1	$35	$35	$35
Part B Drugs-Chemotherapy/Radiation[2,7]	15-2	20% / $450	20% / $450	20% / $450
Part B Drugs-Other[2,7]	15-3	20% / $335	20% / $335	20% / $335

[1] All MA plans are required to establish cost sharing that complies with these limits calculated under § 422.100(f)(6)(iv) and does not exceed either the plan's MOOP limit or overall cost sharing for inpatient benefits in original Medicare on a per member per month actuarially equivalent basis. For the inpatient hospital cost-sharing limits calculated per § 422.100(f)(6)(iv), the inpatient hospital acute 60-day length of stay cost -sharing limit for the lower MOOP type exceeded the lower MOOP limit in Table 3. Therefore, CMS capped the CY 2027 cost sharing limit for the inpatient hospital acute 60-day length of stay at the lower MOOP limit for this scenario.
[2] Section 1876 Cost Plans (per § 417.545(e)(1) and (2)) and MA plans (per § 422.100(j)(1)(i)(A) and (B)) may not charge enrollees higher cost sharing than is charged under original Medicare for Part B chemotherapy administration services, including chemotherapy drugs and radiation therapy integral to the treatment regimen, and renal dialysis services. MA plans (per § 422.100(j)(1)(i)(F)) may not charge enrollees higher cost sharing than is charged under Original Medicare for "Part B drugs – Other." MA plans that establish a lower MOOP amount may charge cost

sharing for home health (provided it does not exceed 20% coinsurance or an actuarially equivalent copayment), while plans with an intermediate or mandatory MOOP amount must not charge higher cost sharing than in original Medicare (per § 422.100(j)(1)(i)(D)). MA plans that establish a mandatory MOOP amount may also not charge enrollees higher cost sharing than is charged under original Medicare for specific DME service categories (per § 422.100(j)(1)(i)(E)).

[3] Section 1876 Cost Plans (per § 417.454(e)(3)) may not charge enrollees higher cost sharing than is charged under original Medicare for skilled nursing care. MA plans (per § 422.100(j)(1)(i)(C)) with a mandatory MOOP may not charge enrollees for the first 20 days of a skilled nursing facility (SNF) stay because their cost sharing cannot exceed cost sharing that is charged under original Medicare for these services. MA plans that establish a lower or intermediate MOOP limit may have cost sharing for the first 20 days of a SNF stay (§ 422.100(j)(1)(i)(C)). The per-day cost sharing for days 21 through 100 must not be greater than one eighth of the projected (or actual) Part A deductible amount, per § 422.100(j)(1)(i)(C)*(1)*. The SNF copayment limit for days 21 through 100 is based on 1/8th of the projected Part A deductible for 2027. Total cost sharing for the overall SNF benefit must not be greater than the actuarially equivalent cost sharing in original Medicare, pursuant to section 1852(a)(1)(B) of the Act, and § 422.100(j)(1)(i)(C).

[4] The dollar amount for Emergency Services and Urgently Needed Services included in the table represents the maximum cost sharing permitted per visit (copayment or coinsurance) and the cost-sharing limit applies regardless of whether the services are received inside or outside the MA organization, per § 422.113(b)(2)(i), (v), and (vi). Emergency and Urgently Needed Services benefits are not subject to plan level deductible amount and/or higher cost sharing for out-of-network providers. In addition, the cost-sharing limit for Urgently Needed Services is based on the limits specified for professional services in § 422.100(f)(6)(iii), per § 422.113(b)(2)(vi).

[5] CMS separated the prior service category, "DME – diabetes monitoring supplies" into two separate service categories that group high (e.g., continuous and blood glucose monitors) and low (e.g., test strips, calibration solution, and lancet) costs together.

[6] The "Part B Drugs – Insulin" service category cost-sharing limit applies to insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). The dollar amount included in the table represents the maximum cost sharing permitted for a one-month's supply of Part B insulin (copayment or coinsurance). The "Part B Drugs – Insulin" benefit is not subject to a service category or plan level deductible.

[7] For Part B rebatable drugs, MA plans (for Part B rebatable drugs in the "Part B Drugs – Chemotherapy/Radiation Drugs" and "Part B Drugs – Other" service categories) and Section 1876 Cost Plans (for Part B rebatable drugs in the "Part B Drugs – Chemotherapy/Radiation Drugs" category) must comply with the lower coinsurance limit used in Original Medicare for the applicable quarter, based on the identification of Part B rebatable drugs for which specific cost-sharing limits apply in original Medicare per IRA section 11101. To comply with this requirement, plans must ensure their in-network cost sharing does not exceed the adjusted Medicare coinsurance for the Part B drugs identified in the quarterly pricing files (e.g., the Average Sales Price (ASP) files). The Medicare coinsurance adjustment may change quarterly or not apply in a subsequent quarter.

NOTE: MA organizations with benefit designs using a coinsurance or copayment amount for which CMS does not have an established limit on cost sharing under §§ 422.100 or 422.113 (e.g., coinsurance for inpatient or copayment for the "DME – Equipment" service category) must submit documentation with their initial bid that clearly demonstrates how the coinsurance or copayment amount satisfies the regulatory requirements for each applicable plan. This documentation may include information for multiple plans and must be identified separately from other supporting documentation submitted as part of the bid pricing tool (BPT). The documentation must be submitted for each PBP through the supporting documentation upload section titled "Cost-Sharing Justification" in HPMS. The upload will be available to all MA plan types (both EGWP and individual market), but not for stand-alone PDPs. The link for uploading cost-sharing justification files will be located at Plan Bids > Bid Submission > CY 2027 > Upload > Cost-Sharing Justification.

Per Member Per Month Actuarial Equivalent Cost-Sharing Limits

Per § 422.100(j)(2), CMS will separately evaluate the PMPM actuarial value of the cost sharing used by each MA plan for the following service categories: Inpatient, Skilled Nursing Facility

(SNF), Durable Medical Equipment (DME), and Part B drugs (including biologics). Whether in aggregate, or on a service-specific basis, this evaluation is done by comparing two values in the plan's BPT. In essence, CMS determines plan compliance by comparing the actuarial value of a plan's PMPM cost sharing for the benefit category to the estimated actuarial value of original Medicare cost sharing for the same benefit category.

For CY 2027, a plan's PMPM cost sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) will be compared to Medicare covered actuarially equivalent cost sharing (BPT Worksheet 4, Section IIA, column n). For Inpatient hospital and SNF services, the Medicare actuarially equivalent cost-sharing values, unlike plan cost-sharing values, do not include Part B cost sharing. Therefore, an adjustment factor is applied to these Medicare actuarially equivalent values to incorporate Part B cost sharing and to make the comparison valid. These adjustment factors for Inpatient and Skilled Nursing Facility in column #4 of Table 5 (Part B Adjustment Factor to Incorporate Part B Cost Sharing) have been updated for CY 2027. Once the comparison amounts have been determined, CMS can evaluate excess cost sharing. Excess cost sharing is the difference (if positive) between the plan cost-sharing amount (column #1 in Table 5) and the comparison amount in column #5 of Table 5 (which reflects an estimated original Medicare cost sharing which is weighted based on the plan's projected county enrollment). This evaluation process remains consistent with prior years and § 422.100(j)(2). Table 5 uses illustrative values to demonstrate the mechanics of this determination for CY 2027.

TABLE 5: ILLUSTRATIVE COMPARISON OF SERVICE-LEVEL ACTUARIAL EQUIVALENT COSTS TO IDENTIFY EXCESSIVE COST SHARING FOR CY 2027

	#1	#2	#3	#4	#5	#6	#7
BPT Benefit Category	**PMPM Plan Cost Sharing (Parts A&B)** ***(BPT Col. l)***	**Medicare FFS Allowed Amount** ***(BPT Col. m)***	**Medicare FFS Actuarially Equivalent Cost Sharing** ***(BPT Col. n)*** [1]	**Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on Medicare FFS Data Projections)**	**Comparison Amount**[2] ***(#3 × #4)***	**Excess Cost Sharing (#1 − #5, min of $0)**	**Pass/Fail**
Inpatient	$33.49	$331.06	$25.30	1.302	$32.95	$0.54	Fail
SNF	$10.83	$58.19	$9.89	1.084	$10.72	$0.11	Fail
DME	$3.00	$11.37	$2.65	1	$2.65	$0.35	Fail
Part B-Rx	$0.06	$1.42	$0.33	1	$0.33	$0.00	Pass

[1] PMPM values in column #3 for Inpatient and SNF only reflect Part A FFS actuarial equivalent cost sharing for that service category.
[2] Estimated original Medicare cost sharing weighted based on the plan's projected county enrollment.

Conclusion

This memorandum includes final bid and operational instructions for MA organizations and, where specified, Section 1876 Cost Plans that may be used in the evaluation of CY 2027 bids submitted by MA organizations.

Unless otherwise noted in an applicable final rule, this document, or other specific guidance, CMS will continue existing policies and instructions regarding bid submission from the prior year. A more complete discussion of such existing and continuing policies is available in the Final CY 2020 Call Letter (found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf). For example, the policies regarding incomplete and inaccurate bid submissions and plan corrections are discussed on pages 163-166 of the CY 2020 Call Letter.

APPENDIX

This appendix provides Medicare Advantage (MA) organizations and, where specified, Section 1876 Cost Plans, with technical instructions on bid development and submission; details steps in evaluating changes in Total Beneficiary Cost (TBC); highlights important benefit policies; and reviews the contract year (CY) 2027 Plan Benefit Package (PBP) data entry instructions, as CMS has done in prior years.

Total Beneficiary Cost (TBC)

This section provides additional information for calculating the TBC for each MA plan, as discussed in the TBC section of this memorandum.

For CY 2027 bids, CMS will maintain the process used in prior years for consolidating or crosswalking plans when conducting the TBC evaluation. Each individual plan being consolidated/crosswalked into another plan must meet the TBC requirement on its own merit. Therefore, the TBC adjustment factors for each plan being consolidated/crosswalked will be part of the calculation as if the plan were continuing. For example, if Plan A is being consolidated/crosswalked into Plan B: (i) Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B and (ii) Plan B's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan B.

The following describes how the TBC evaluation will be conducted for organizations that consolidate/crosswalk and/or segment plans from one year to the next:

- Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2026 plan will be compared independently to the CY 2027 plan.
- Segmenting an existing plan: TBC for each CY 2027 segmented plan will be compared independently to the CY 2026 non-segmented plan.
- Consolidating/crosswalking previously segmented plans into one non-segmented plan: TBC of each existing CY 2026 segmented plan will be compared independently to the non-segmented CY 2027 plan.
- Consolidating/crosswalking segmented plans into other segmented plans: TBC of each existing CY 2026 segmented plan will be compared independently to the segmented CY 2027 plan.

If CMS provides the MA organization an opportunity to address CY 2027 TBC issues following the bid submission deadline, the MA organization may not change its formulary (e.g., adding drugs, etc.) as a means to satisfy TBC. The formulary review process has multiple stages and making changes to satisfy TBC and are unrelated to CMS-identified formulary review concerns negatively affects the formulary and bid review process. For example, portions of the annual formulary review process are based on outlier analyses. If an MA organization were permitted to make substantial formulary changes after the initial reviews, these analyses could be adversely impacted. In addition, significant formulary changes necessitate additional CMS review outside of the normal review process and may jeopardize the approval of an organization's formulary and could affect approval of its contract.

The plan-specific data elements that CMS posts on HPMS for purposes of the TBC evaluation are shown in the table below. This information may be accessed in HPMS by selecting: Quality and Performance > Performance Metrics > Reports > Costs > Part C Total Beneficiary Costs. The calculation shown in the table accounts for changes in quality bonus payment and/or rebate percentage or star rating (as described above) so all plans are evaluated against the $40.00 PMPM TBC change threshold. Should there be any changes due to the quality bonus payment appeals process, plan sponsors will be notified of their corresponding revised TBC adjustment factor.

Plan-Specific TBC Calculation

Steps	Item	Item	Description
CY 2026 TBC	A	OOPC value	Each of these plan-specific values will be provided by CMS through an HPMS posting
	B	Premium (net of rebates)	
	C	Total TBC	
CY 2027 TBC	D	OOPC value	Plan calculates using OOPC Model Tools
	E	Premium (net of rebates)	Bid Pricing Tool, Worksheet 6, Cell R45 + Cell E14 - Cell L14
	F	Total TBC	Calculation: D plus E
Apply TBC Adjustments	G	Unadjusted TBC Change	Calculation: F minus C
	Payment adjustments (including county benchmark, quality bonus payment, and/or rebate percentages)		
	H	Gross Payment Adjustment	Plan-specific value will be provided by CMS through an HPMS posting
	I	Plan Situation	CMS determines whether the TBC calculation is modified for each plan to account for changes in quality bonus payment and/or rebate percentage or star rating through an HPMS posting
	J	Payment Adjustment Based on Plan Situation	Plan-specific value will be provided by CMS through an HPMS posting
	Technical Adjustments		
	K	Part B premium adjustment for the difference between the maximum Part B premium buy-down for CY 2026 ($185.00) and the amount for CY 2027 ($202.90)	Value is $17.90 for all plans
	L	Impact of changes in OOPC Model between CY 2026 and CY 2027	Plan-specific value will be provided by CMS through an HPMS posting

Steps	Item	Item	Description
Evaluation	M	Adjusted TBC Change	Calculation: G + J - K - L Plan is likely to pass the TBC evaluation if M is less than or equal to $40.00 PMPM

As described in the table above, CMS will provide, through the HPMS posting, CY 2026 TBC plan-specific information including OOPC value (Item A), Premium (net of rebates) (Item B), and Total TBC (Item C). Premiums used in this calculation will be inclusive of plan premium and Part B premium paid by the enrollee as reflected in the CY 2026 BPT. MA organizations will be able to calculate their plan-specific CY 2027 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2027 (Item E). Premium (net of rebates) can be found in the CY 2026 BPT, Worksheet 6, Cell R45 + Cell E14 - Cell L14.

The Unadjusted TBC Change between CY 2026 and CY 2027 (Item G) is the difference between CY 2026 Total TBC (Item F) and CY 2025 Total TBC (Item C), i.e., G = F - C. The Adjusted TBC Change amount (Item M) reflects the impact of the payment adjustment and technical adjustments. CMS will provide PBP-specific payment adjustment information through the HPMS posting. The Gross Payment Adjustment (Item H) accounts for changes in county benchmark, and quality bonus payment and/or rebate percentages. The Plan Situation (Item I) defines whether the TBC calculation will be modified with an alternative Payment Adjustment based on the Plan Situation (Item J) to account for changes in the quality bonus payment and/or rebate percentage or star rating as indicated in the following table:

Plan Situation (Item I)	Payment Adjustment Based on the Plan Situation (Item J)
Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount (Item H) greater than $40.00 PMPM	Maximized at $40.00 PMPM
Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount (Item H) less than -$40.00 PMPM	Minimized at -$40.00 PMPM
Plans with a star rating below 3.0 and an overall payment adjustment amount (Item H) less than -$40.00 PMPM	Minimized at -$40.00 PMPM
Plans that are not accounted for in the three categories above	Same as Gross Payment Adjustment

The HPMS posting also provides Technical Adjustments, including Part B premium adjustment (Item K) and the Impact of Changes in the OOPC model between CY 2026 and CY 2027 (Item L). The Adjusted TBC Change amount (Item M) is calculated by first adding to the Unadjusted TBC Change (Item G) the Payment Adjustment Based on Plan Situation (Item J), then

subtracting Item K and Item L.[6] The formula for applying the adjustments to calculate the Adjusted TBC Change amount is represented as follows: M = G + J - K - L. In this illustrative scenario, plan bids with an Adjusted TBC Change amount (Item M) equal to or less than $40.00 PMPM will have passed the TBC evaluation. CMS also reminds MA organizations that the Office of the Actuary extends flexibility on margin requirements so MA organizations can satisfy the TBC requirement. As noted above, CMS reserves the right to further examine and request changes to a plan bid even if a plan's TBC is within the required amount.

Illustrative Calculation for Payment Adjustments

As described above, CMS adjusts the TBC calculation to reflect payment changes from one year to the next. The following table provides examples of how the payment adjustment is calculated. The Payment Adjustment is the CY 2027 rebate minus the CY 2026 rebate. The CY 2026 Bid Amount and Benchmark are taken from the plan-submitted CY 2026 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2026 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2026 ratebook. The CY 2027 Benchmark is the weighted average of county-specific payment rates using the CY 2027 ratebook and projected enrollment from the CY 2026 BPT. The rebate percentage is dependent on the plan's Quality Bonus Payment (QBP) rating for each year. The rebate is calculated as the amount by which the Benchmark exceeds the Bid Amount, multiplied by the rebate percentage.

Illustrative Calculation Examples

Bid ID	2026 Values					2027 Values					Rebate Difference	Payment Adj.	TBC Threshold
	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*			
Plan 001	3	$1,000.00	$950.00	50%	($50.00)*	3	$1,044.00	$991.80	50%	($52.20)*	($2.20)	($2.20)	$42.20
Plan 002	3	$1,000.00	$1,050.00	50%	$25.00	3	$1,044.00	$1,096.20	50%	$26.10	$1.10	$1.10	$38.90
Plan 003	3	$1,000.00	$1,300.00	50%	$150.00	3.5	$1,044.00	$1,357.20	65%	$203.58	$53.58	$40.00	$0.00
Plan 004	3.5	$1,000.00	$1,500.00	65%	$325.00	3	$1,044.00	$1,566.00	50%	$261.00	($64.00)	($40.00)	$80.00
Plan 005	3.5	$1,000.00	$1,300.00	65%	$195.00	4	$1,044.00	$1,422.20	65%	$245.83	$50.83	$40.00	$0.00
Plan 006	4	$1,075.00	$1,100.00	65%	$16.25	3.5	$1,122.30	$1,093.40	65%	($28.90)*	($45.15)	($40.00)	$80.00
Plan 007	2.5	$1,000.00	$1,300.00	50%	$150.00	2.5	$1,044.00	$1,250.00	50%	$103.00	($47.00)	($40.00)	$80.00

* Indicates that the amount is a premium.

Note: Slight variances in numbers are due to rounding.

[6] CMS notes that, although it uses different mathematical operations to apply the adjustment associated with Item J (i.e., addition) and Item L (i.e., subtraction), either of these Items can cause the TBC to increase or decrease, depending on whether the amount associated with each Item is a positive or negative number.

Illustrative Calculation Descriptions

a. Plans 001 through 004 have benchmark growth of 4.4%.
b. Plan 001 bid amount is greater than the benchmark in both years (and Plan 006 in 2027); therefore the difference is not multiplied by the rebate percentage. The amount by which the bid exceeds the benchmark must be paid by (or on behalf of) the enrollee as the MA premium.
c. Plan 002 (and Plans 003-007) the difference is multiplied by the rebate percentage when the bid amount is less than the benchmark.
d. Plan 003 has an increase in rebate percentage; therefore the payment adjustment is maximized at $40 PMPM.
e. Plan 004 has a decrease in rebate percentage; therefore the payment adjustment is minimized at -$40 PMPM.
f. Plan 005 has benchmark growth of 4.4% plus a quality bonus in the form of a 5 percentage point increase to simulate gaining a bonus payment; therefore the payment adjustment is maximized at $40 PMPM.
g. Plan 006 has benchmark growth of 4.4% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$40 PMPM.
h. Plan 007 has a 2027 star rating below 3.0; therefore the payment adjustment is minimized at -$40 PMPM.

CMS encourages organizations to participate in the Actuarial User Group Calls conducted by the Office of the Actuary. These calls provide organizations with the opportunity to ask technical questions related to this calculation.

Maximum Out-of-Pocket (MOOP) Limits

The following chart identifies how MA plans may enter the MOOP in the PBP and whether the MOOP applies to in-network cost sharing, a combination of in-network and out-of-network cost sharing, or both, by plan type:

CY 2027 PBP Options for Entering MOOP Amounts by Plan Type

Plan Type	**Required MOOP Amounts**	**Plan also may choose to enter in the PBP:**
HMO	In-network	“In-network” is only option available in the PBP
HMO with Optional Supp. Point of Service (POS)	In-network	“In-network” is only option available in the PBP
HMO with Mandatory Supp. POS	In-network	“No" or enter amounts for “Combined” and/or “Out-of-Network” as applicable
Local Preferred Provider Organization (LPPO)	In-network and Combined	“No” or enter an amount for “Out-of-Network” as applicable
Regional Preferred Provider Organization (RPPO)	In-network and Combined	“No” or enter an amount for “Out-of-Network" as applicable

Plan Type	Required MOOP Amounts	Plan also may choose to enter in the PBP:
PFFS (full network)	PFFS Amount	In-Network and Out-of-Network is optional (as applicable) and Combined is required
PFFS (partial network)	PFFS Amount	In-Network and Out-of-Network is optional (as applicable) and Combined is required
PFFS (non-network)	PFFS Amount	"Non-Network" is the only option available in the PBP

NOTE: While Section 1876 Cost Plans are not required to have a MOOP, CMS encourages cost plans to consider including one. If cost plans do include a MOOP they must specify in their communications to enrollees how the MOOP is calculated to avoid beneficiary confusion.

CY 2027 Part C PBP Data Entry Expectations

Updated Medicare Benefit and Service Category Descriptions

CMS updated the PBP Medicare benefit and service category descriptions in HPMS and encourages MA organizations to review this information to make sure proposed benefits are consistent with CMS definitions and instructions for the bid. Under 42 CFR § 422.254, MA organizations are responsible for submitting accurate and complete bids that provide all necessary information for bid evaluation. The updated service category and Medicare benefit descriptions can be viewed under the HPMS Bid Reports section of HPMS (Navigation Path: Plan Bids > Bid Reports > CY 2027 > Plan Benefit Reports > Service Category Report and Plan Bids > Bid Reports > CY2027 > Plan Benefit Reports > Medicare Benefit Description Report).

Diabetic Monitors

A new Medicare-covered PBP service category 11c3 "Diabetic Monitors" has been added to capture cost sharing and benefit information specifically for items such as blood glucose monitors and continuous glucose monitors, as well as ambulatory infusion pumps. Cost sharing for these items should not be duplicated in other service categories such as 11c1 "Diabetic Supplies."

Hearing Benefits

The Hearing (18) category in the Benefit Details section of the PBP has been updated to capture maximum plan benefit coverage combinations that include all three hearing subcategories: Hearing Exams (18a), Prescription Hearing Aids (18b), and OTC Hearing Aids (18c). MA plans should indicate a single maximum plan benefit coverage amount shared between the 18a, 18b, and 18c categories by entering the maximum amount in 18a: Hearing Exams and then selecting "Covered under Hearing Exams Category (18a)" on the 18b: Prescription Hearing Aids and 18c: OTC Hearing Aids screens. A shared maximum plan benefit coverage amount may similarly be combined for 18a and 18b, 18a and 18c, or 18b and 18c. Select "Plan-specified amount per period" if the maximum plan benefit coverage amount is not shared with another category in 18: Hearing Exams/Hearing Aids."

MA Uniformity Flexibility (MA UF)/Special Supplemental Benefits for the Chronically Ill (SSBCI)

For MA UF and SSBCI Reduction in Cost Sharing and Additional Benefits packages, MA plans will be able to list up to 10 "Other" chronic conditions/disease states in CY 2027 (an increase from 5 in CY 2026). The list of chronic conditions available for selection under SSBCI are consistent with the conditions defined at 42 CFR § 422.2 "Severe or disabling chronic conditions." MA plans should refer to section 422.2 to determine if the specific chronic condition(s) they want to identify as potentially eligible for SSBCI appropriately falls within one of the 22 chronic condition categories identified in the PBP (e.g., a plan offering an SSBCI package to eligible enrollees with "coronary artery disease" would select the "Cardiovascular disorders" chronic condition category). Only those chronic conditions/disease states that do not fall within the 22 chronic condition selections for SSBCI or the 15 disease state selections for MA UF should be included as an "Other" entry.

For SSBCI Reduction in Cost Sharing and Additional Benefits packages, two fields have also been added to the PBP for plans to enter the "Expected number of chronically ill enrollees eligible for SSBCI" and the "Expected number of chronically ill enrollees that will utilize SSBCI" for each SSBCI package. MA plans should enter in those fields an estimate of the number of chronically ill enrollees that may be eligible for, and are expected to utilize, one or more of the benefits within the SSBCI package.

Using Appropriate Benefit Categories

An accurate bid will have cost-sharing amounts entered for a particular service in a manner that reflects the cost sharing charged across ALL possible healthcare settings (e.g., physician's office, outpatient hospital, free-standing facility, etc.) for that service and is not duplicated in multiple PBP locations. Plans that duplicate the cost-sharing entry based on the place of service instead of the service category in the PBP will be asked to correct the bid submission.

Benefits for which there is no identified PBP category may be entered in 13d, e, or f (13- Other). Plans should confirm there is not an appropriate category already provided in the PBP before entering data in 13-Other.

Combined Supplemental Benefits (CSB)

MA plans must enter benefits with a combined maximum plan benefit amount or benefits with a combined visit limit as a "Combined Supplemental Benefits (CSB)" group in the PBP "Cost Share Groups" section. Generally, MA plans should only enter the single, combined maximum plan benefit amount in the CSB group and not duplicate the amount within the individual service categories under the PBP Benefit Details section. Instead, MA plans should select "no" for the maximum plan benefit amount in the service categories under Benefit Details that are applicable to the CSB group.

Previously, there were specific exceptions where plans were instructed to duplicate a combined maximum plan benefit amount included in the Dental (16b/c), Vision (17a/b), and Hearing (18a/b/c) Benefit Details sections in a CSB benefit package. For CY 2027, plans with a

combined maximum amount limited to only within the Dental, Vision, and/or Hearing categories will no longer duplicate the maximum in a CSB group. The combined maximum amount will only be identified on the 16b/c, 17a/b, and 18a/b/c Benefit Details screens. For example, an MA plan that has a $1,000 combined maximum amount for Preventive Dental (16b) and Comprehensive Dental (16c) would enter in the Benefit Details section a 16b maximum of $1,000 and in 16c select "Covered under 16b," but would no longer enter a CSB.

MA plans also must now specify which PBP service categories from Additional MA UF and/or SSBCI packages are included in a Combined Supplemental Benefit (CSB) group. Two questions related to maximum plan benefit and shared visit/trip limits have been added to the CSB page:

- "Are the benefits combined such that a single benefit maximum available to all enrollees in the benefit details section is extended to an SSBCI or MA UF benefit for eligible enrollees?"
- "Are the benefits combined such that a single visit or trip limit available to all enrollees in the benefit details section is extended to an SSBCI or MA UF benefit for eligible enrollees?"

MA plans should answer these questions affirmatively if they are extending a benefit coverage limit available to all enrollees to benefits for which only MA UF or SSBCI enrollees may be eligible. For example, the MA plan covers OTC (13b) for all enrollees up to a $350 maximum amount per year and extends the same $350 OTC maximum amount to SSBCI eligible enrollees for coverage of Food and Produce (19b/13i1).

Updated PBP data entry instructions with several examples of common benefit designs are described in the CY 2027 PBP User Guide within HPMS (Navigation Path: Plan Bids > PBP > Documentation > PBP CY2027 User Guide) under the "Combined Supplemental Benefits (CSB)" section. MA plans should review these examples to ensure their CY 2027 benefit data is entered in the PBP appropriately.

PBP Notes

Most PBP sections do not require a note, particularly when an MA organization provides benefits consistent with the descriptions for a particular benefit in Chapter 4 of the MMCM, HPMS memoranda, and the description of benefits provided for each PBP category; however, if a plan is offering more extensive services for a particular supplemental benefit, the note should describe only those services that are over and above what is described in Chapter 4.

Some benefits and certain PBP categories require additional information to clarify what the MA plan will cover. The table below indicates the specific circumstances and PBP categories that require a note and the information that is necessary for an accurate and complete bid to be submitted for CMS review. To avoid potential mismatches, refrain from including actual cost sharing or maximum coverage amounts in the notes.

Category/Circumstance	Information required in the note
Combined Supplemental Benefit (CSB) Groups	Refrain from entering notes for the CSB group since the data entry should be sufficient. For example, the mode of delivery, combined maximum coverage amount, visit/trip limit and list of benefit categories are captured in the data entry and should not be repeated in the notes. Additionally, refrain from repeating the CSB group information within the notes of the benefit categories. For example, the combined maximum amount and visit/trip limit are captured in the data entry and need not be repeated in the notes. Refer to the PBP User Guide for further data entry instructions.
Cost-Sharing Range (copay range, coinsurance range, both copay and coinsurance charged)	In each category containing a cost-sharing range, describe the minimum and maximum cost-sharing amount and any highly utilized services in between; include explanations of cost sharing associated with various places of service. When both a copay and coinsurance are charged, indicate when the copay applies versus when the coinsurance applies. Refrain from using dollar amounts in notes to avoid mismatches with the data entry. For example, the note could state: "The min copay applies to (service 1) and the max copay applies to (service 2)." A note could also state: "The copay applies to (service 1) and the coinsurance applies to (service 2)."
Tiering of Cost-Sharing for Medical Benefits	Describe any tiered cost-sharing amounts. Refrain from using dollar amounts in notes to avoid mismatches with the data entry. For example, an acceptable note could state "The min copay applies to tier 1 providers and the max copay applies to tier 2 providers."
13c: Meals	**Meals provided for a limited period of time:** Post inpatient hospitalization/surgery Include the number of meals and/or days covered for each event and the number of events applicable for the year. Chronic condition Include the chronic conditions eligible for the meal benefit and the number of meals and/or days covered for each chronic condition. Other medical condition

Category/Circumstance	Information required in the note
	Include a brief description for "other" medical conditions that require the enrollee to remain at home for a period of time and the number of meals and/or days provided for the other medical conditions.
13def: Other Supplemental Benefits	Briefly describe the benefit that does not meet the definition of another defined category in the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c4: Fitness Benefit	Physical fitness: Include a brief description of the physical fitness services covered (e.g., gym/fitness club membership, fitness classes). Plans may include mention of a vendor(s) or a program(s) when describing the in-network portion of the benefit, but the note should focus on describing the actual covered fitness services. Fitness benefits must not include social programs or events, park passes, fees related to sport leagues or club sport memberships or competitions, and cannot include requirements for attendance or performance. Memory fitness: Include a description of the type of brain/memory exercises offered. Puzzles and games are not considered a memory fitness primarily health related supplemental benefit. Activity Tracker If the plan only offers an activity tracker, the note does not need to include any details other than "activity tracker." If the plan describes a smart watch as the activity tracker, include in the note that the watch is limited to health related uses. Fitness Equipment or Kit Include a list of the fitness equipment covered. If the benefit is for a "kit" include a brief summary of the components of the kit and list any equipment included. Fitness equipment must not include general use items such as sneakers and athletic clothing or merchandise such as sporting goods.
14c6: Telemonitoring	Include the condition(s) being monitored and briefly explain the monitoring process (i.e., the frequency of data collection, the device used, and the physician's involvement).

Category/Circumstance	Information required in the note
14c7: Remote Access Technologies	Web/Phone-based Technologies Include a description of the technology used and the services provided that are not Medicare-covered or Additional Telehealth Benefits under § 422.135. Do not use the term "telehealth." Ensure that only supplemental benefits are included. Nursing Hotline No note is required.
14c8: Home and Bathroom Safety Devices	List the devices being offered.
14c14: Readmission Prevention	If "meals" is selected, include the number of meals and/or days covered for each event and the number of events applicable for the year. If "other" is selected, include a brief description of the benefit offered.
14c16: Weight Management Programs	Include a brief description of the benefit which may include program brand names, if applicable. If programs that typically include meals are offered, meals must not be covered as part of the weight management benefit (because meals are a permitted supplemental benefit only when all criteria in § 422.100(c)(2)(ii) are met) and the note must state that meals are not covered as part of this benefit.
14c17: Alternative Therapies	List the therapies offered that are not included in other categories of the PBP. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
14c19: Adult Day Health Services	Briefly describe the benefit being offered such as assistance with activities of daily living (ADLs)/instrumental activities of daily living (IADLs). Do not reference companionship as this is not considered a primarily health related supplemental benefit.
14c20: Home-Based Palliative Care	Briefly describe the benefit being offered.
14c21: In-Home Support Services	Briefly describe the benefit being offered such as assistance with ADLs/IADLs. Do not reference companionship as this is not considered a primarily health related supplemental benefit.
14c22: Support for Caregivers of Enrollees	Describe the benefit being offered for ALL selections made (Respite Care, Caregiver Training, and Other). Some caregiver training is now covered by Original Medicare. Ensure any caregiver training described is a supplemental benefit.

Category/Circumstance	Information required in the note
MA Uniformity Flexibility, SSBCI-13def: Other Supplemental Benefits	Briefly describe the benefit and confirm it does not meet the definition of another category of the PBP and is primarily health- related. Also confirm the benefit does not duplicate a benefit already indicated in PBP service categories 1-18, 20 (referred to as the base bid). MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/.
SSBCI -13i: Non-Primarily Health Related Special Supplemental Benefits for the Chronically Ill (SSBCI, § 422.102(f))	Add a brief description for each benefit being offered in the appropriate subcategory. Only add a note that is specific to that particular category. Do NOT duplicate the same note across all categories.
SSBCI -13i-O: Non-Primarily Health Related Special Supplemental Benefits for the Chronically Ill (SSBCI, § 422.102(f))), Other	Briefly describe the benefit and confirm that it does not meet the definition of another PBP category. Confirm that the benefit does not duplicate one that is already indicated in the base bid. Also ensure that primarily health related benefits are entered in 13def, not 13i-O. MA organizations may seek guidance from CMS regarding supplemental benefits not defined in the PBP or in previous CMS guidance by submitting a question to the MA benefits mailbox prior to the bid submission deadline: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/ .
PPO Out-of-Network (OON) Benefits	Ensure the OON notes do not reference limiting access for covered benefits to in-network providers or vendors.
Optional Supplemental Benefit (OSB) Packages	Ensure the OSB package notes do not reference debit cards as a tool for administering optional supplemental benefits. MA organizations should not select "debit card" as a mode of delivery for OTC offered through an OSB package.

Plans should not include the following in any PBP notes:

- Authorization and referral protocols (the information entered in the PBP data is sufficient)
- Codes (e.g., ICD-10 codes, CPT codes)
- Names of specific drugs
- References to the BPT or marketing materials
- Vague terms (e.g., "etc.", "misc.", "extended period of time", "other")
- Restatements of the PBP question(s) or information already indicated in the PBP data fields
- Original Medicare coverage descriptions or guidelines
- Supplemental benefit descriptions from MMCM Chapter 4
- References to state or Medicaid benefits

- References to Part D benefits (except in Rx PBP Notes section, where applicable)
- Value-added Items and Services
- Rewards or incentives
- Phone numbers or websites
- References to Model of Care (MOC) requirements

Other Important Reminders

Special Supplemental Benefits for the Chronically Ill (SSBCI)

The Bipartisan Budget Act of 2018 (Public Law No. 115-123) amended section 1852(a)(3) of the Social Security Act to expand the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees. CMS refers to these as Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI may include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees, provided that the SSBCI, with respect to the chronically ill enrollee, has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. CMS codified at 42 CFR § 422.102(f)(1)(iii), as amended in the Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly final rule[7] (the CY 2026 Final Rule) and the Medicare Program; Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program final rule[8] (the CY 2027 Final Rule) a non-exhaustive list of non-primarily health related items or services that do not have a reasonable expectation of improving or maintaining the health of a chronically ill enrollee and therefore cannot be offered as SSBCI. Examples of items and services that may not be offered as SSBCI include all of the following: non-healthy food, alcohol, tobacco, cannabis products that are illegal under applicable State or Federal law, funeral planning and expenses, life insurance, hospital indemnity insurance, broad membership programs inclusive of multiple unrelated services and discounts, and procedures that are solely cosmetic in nature and do not extend upon Original Medicare coverage (e.g., cosmetic surgery, such as facelifts or cosmetic treatments for facial lines, atrophy of collagen and fat, and bone loss due to aging).

Plans are reminded that 42 CFR § 422.102(f)(1)(i)[9] defines a chronically ill enrollee as an individual who:

1) has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
2) has a high risk of hospitalization or other adverse health outcomes; and
3) requires intensive care coordination.

All three criteria must be met for an enrollee to be eligible for the SSBCI.

Healthy Food and Produce

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[7] https://www.federalregister.gov/d/2025-06008
[8] https://www.federalregister.gov/d/2026-06600
[9] See also section 1852(a)(3)(D) of the Act.

The Make America Healthy Again (MAHA) initiative is a health policy framework focused on addressing chronic disease through preventive care, nutrition, and wellness interventions. The initiative's objectives center on reducing chronic illness by addressing underlying causes, with particular emphasis on the role of nutrition in preventing and managing conditions such as diabetes, heart disease, and obesity among Medicare beneficiaries. MAHA's key principles include promoting access to whole, unprocessed foods, reducing exposure to harmful additives and ultra-processed products, supporting local and sustainable food systems, and facilitating informed dietary choices.

CMS reminds Medicare Advantage plans that they may offer a range of health and wellness-related supplemental benefits to meet the objectives of the MAHA initiative. These include fitness benefits such as gym memberships, medical nutrition therapy, enhanced disease management, and medically tailored meals.[10] As Special Supplemental Benefits for the Chronically Ill (SSBCI), plans are permitted to offer unlimited meal benefits as well as food and produce to assist chronically ill enrollees in meeting their nutritional needs and providing ongoing support for beneficiaries with chronic conditions. These existing benefit categories provide plans with substantial flexibility to design nutrition and wellness interventions that support enrollee health and wellness.

As outlined in the CY 2026 Final Rule, CMS clarified that non-healthy food —food that does not assist in meeting the nutritional needs of a chronically ill enrollee —is not permitted as an allowable SSBCI. To assist plans in designing benefits that align with HHS nutritional standards, CMS is providing the following examples of foods that could reasonably be offered as part of nutrition-related SSBCI benefits. These foods include, but are not limited to:

- Fruits and vegetables
- Whole grains
- Legumes
- Nuts and seeds
- Proteins from a variety of animal- and plant-based sources, including eggs, poultry, seafood, beans and lentils
- Healthy fats such as olive oil, avocados, and fatty fish

These examples align with the 2025-2030 Dietary Guidelines for Americans[11]. CMS encourages plans to prioritize whole, minimally processed foods when designing food benefits to ensure those benefits assist in meeting the nutritional needs of chronically ill enrollees.
CMS also reminds MA plans of their ability to incentivize enrollee participation in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources. An example of a Reward and Incentives (R&I) program that would support the MAHA initiative may include offering gift cards to enrollees for completion of a specified number of medical nutrition therapy sessions for those who are eligible.[12] R&I programs are not benefits but may encourage utilization of plan benefits toward fostering a healthy lifestyle.

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[10] Medically tailored meals may be offered on a limited basis following a qualifying health event.
[11] https://www.dietaryguidelines.gov/
[12] CMS reminds plans that R&I programs must not be discriminatory and must otherwise comply with program requirements at 42 CFR § 422.134.

Fitness Benefits

Fitness benefits (e.g., a fitness center membership, exercise and yoga classes) may be offered by MA plans as supplemental benefits designed to improve or maintain good health. Per CMS regulations at 42 CFR § 422.100(c)(2)(ii), CMS defines a mandatory or optional supplemental health care benefit as an item or service (1) not covered by Medicare Parts A, B or D, (2) that is primarily health related, and (3) for which the plan must incur a non-zero direct medical cost. Additionally, per CMS regulations at 42 CFR § 422.100(c)(2)(ii)(A), an item or service is considered "primarily health related" if it diagnoses, prevents, or treats an illness or injury; compensates for physical impairments; acts to ameliorate the functional/psychological impact of injuries or health conditions; or reduces avoidable emergency and health care utilization. An item or service that meets all three conditions above may be proposed as a supplemental benefit in a plan's PBP. Further, as stated in Programs: Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [13] (86 FR 5864), a supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.

Plans are reminded that items and services included in the PBP under the "Fitness benefit" category must be primarily health related in accordance with the above definition. Consistent with this requirement, any device covered as an activity tracker under the "Fitness benefit" may only be used for primarily health related purposes. Therefore, these devices must be locked except for health related uses such as fitness tracking, remote monitoring, or to enable engagement with healthcare providers. CMS also reminds plans that a benefit that provides access to permissible fitness activities must be non-transferrable and only available to enrollees, consistent with the plan's coverage criteria (see § 422.100(d)(2)(ii)). MA plans should describe specifically what is included in the supplemental fitness benefit in the 14c4: Fitness Benefits PBP notes field. Examples of fitness-related items and services that do not meet the definition of primarily health related include sneakers, athletic clothing or merchandise such as sporting goods, fees related to sport leagues or club sport memberships, competitions, social programs or events, and park passes.

Debit Cards as a Tool in Administering Covered Benefits

In the CY 2027 Final Rule, CMS codified and further clarified requirements for MA plans that administer supplemental benefits — including over-the-counter (OTC) items and Special Supplemental Benefits for the Chronically Ill (SSBCI)—through debit cards. As a result of this rule, plans are reminded that the following are required: 1) debit card dollar amounts and benefit allocations must be limited to the applicable plan year with no carryover; 2) plans must maintain an alternative reimbursement process for eligible expenses in circumstances where the debit card is unusable at the point of sale, including due to malfunction or other technical failures or when a beneficiary is entitled to obtain covered benefits out-of-network; 3) plans must comply with strengthened disclosure requirements under § 422.111(b)(6), which now require plans to disclose all supplemental benefits—including applicable conditions and limitations, all eligible OTC items, and which specific benefits may be accessed via debit card; and 4) plans must ensure

[13] https://www.federalregister.gov/d/2021-00538

enrollees have access to adequate support to understand and use their debit card benefits effectively.

Plans are also reminded that debit cards are not unrestricted cash cards. If a plan cannot appropriately restrict a debit card to covered benefits — for example, through merchant codes or inventory approval system codes—a debit card is not an appropriate administration mechanism for that plan. Plans are also reminded that 42 CFR § 422.102(a)(6) permits MA plans to administer reduced cost sharing—up to and including 100%—through debit cards. Plans should be aware that reduced cost sharing under 42 CFR § 422.102(a)(6), including reduced cost sharing as part of a maximum plan allowance, is only available as a mandatory supplemental benefit. Debit cards may not be used to administer optional supplemental benefits.

Preferred Provider Organization (PPO) Out-of-Network (OON) Coverage

MA PPO plans must cover all covered benefits regardless of whether those services are furnished within the plan's contracted provider network (42 C.F.R. § 422.4(a)(1)(v)). The CY 2027 Final Rule reiterates this existing requirement, including that it applies regardless of the mechanism through which a covered benefit is furnished. An out-of-network benefit that is limited to a certain vendor(s), or a catalog for a certain vendor(s), even if the benefit is nationally available to all enrollees, does **not** satisfy the PPO requirement of covering the benefit in-network and out-of-network. Plans should review their policies and procedures to confirm consistency with this requirement.

Alternative Ambulance Transportation/Non-Transport Supplemental Benefit

Medicare Fee-for-Service covers ambulance transportation when a beneficiary needs to be transported, from a specific location (for example, the beneficiary’s home) to a limited number of destinations, including a hospital or skilled nursing facility but limited to the locations specified in 42 CFR § 410.40(f), for emergency services or for other medically-necessary services when transportation in any other vehicle could endanger the beneficiary’s health. In some cases, Medicare Fee-for-Service may pay for limited, medically necessary, non-emergency ambulance transportation if the beneficiary has a written order from the doctor stating that ambulance transportation is medically necessary. For example, a beneficiary with End-Stage Renal Disease (ESRD) may need a medically necessary ambulance transport to a facility that furnishes renal dialysis. Medicare will only cover ambulance services to the nearest appropriate medical facility that is able to give the beneficiary the care needed. For more information, see 42 CFR §§ 410.40 and 410.4, and Medicare Benefit Policy Manual, Ch. 10.

MA plans may provide a supplemental benefit that covers ambulance services on a broader basis than Original Medicare coverage. This could include: (1) transport to an alternative destination appropriate to treat the beneficiary’s condition, such as a primary care office, urgent care clinic, or a community mental health center; and (2) initiating and facilitating treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. This type of supplemental benefit should be entered in the PBP at Section 13d,e,f-Other.

Important Administrative Information

CMS uses HPMS for significant communications with MA organizations. MA organizations must regularly update contact information in the HPMS Contract Management module to ensure that communications between CMS and the MA organization includes the correct individuals. In addition, CMS will use the PCT@LMI.org email address to communicate with MA organizations for MA benefits review. Therefore, please ensure your organization's email system can receive emails from this address.

CMS reminds MA organizations that the OOPC models are available on the CMS website. All documentation and instructions associated with running the OOPC model are posted on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html. Prior to uploading an MA plan bid, MA organizations should run their plan benefit structures through the OOPC model to make sure the plan offerings comply with applicable MA benefit requirements and bid evaluation standards.

Questions may be directed to the appropriate mailbox or website as specified below:

- For technical HPMS questions (e.g., PBP download, plan creation, bid upload), please contact the HPMS Help Desk at 1-800-220-2028; hpms@cms.hhs.gov;
- For technical questions about the Out-of-Pocket Cost (OOPC) model, please submit an email to OOPC@cms.hhs.gov;
- For Medicare Advantage policy questions, please submit to https://DPAP.lmi.org/DPAPMailbox/;
- For Medicare Advantage benefits questions, please review available resources (e.g., HPMS memoranda) before submitting questions to https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/;
- For crosswalks, plan consolidation and provider specific plan (PSP) questions, please submit to https://DMAO.lmi.org/DMAOMailbox;
- For marketing or communication material questions, please submit an email to marketing@cms.hhs.gov;
- For Part D benefits questions, please submit an email to PartDBenefits@cms.hhs.gov;
- For technical questions about the Bid Pricing Tool (BPT), please submit an email to actuarial-bids@cms.hhs.gov; or
- For questions related to the Inflation Reduction Act, please submit an email to IRARebateandNegotiation@cms.hhs.gov;
- For questions related to D-SNP out-of-network cost-sharing rules, please submit an email to MMCO_DSNPOperations@cms.hhs.gov.