DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 16, 2025

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

FROM: Kathryn A. Coleman
Director

SUBJECT: Final Contract Year (CY) 2026 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 CY 2026 and applies standards in regulation applicable to CY 2026.

On February 21, 2025, CMS issued a preliminary HPMS memorandum to solicit comment on its interpretation and application of various MA regulations regarding benefit standards for CY 2026 (HPMS memorandum titled, "Preliminary Contract Year (CY) 2026 Standards for Part C Benefits, Bid Review and Evaluation"). In the preliminary memorandum, CMS detailed how the CY 2026 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 TBC, MOOP, and cost-sharing standards are summarized and addressed in detail within the corresponding sections of this memorandum. After consideration of the comments received, CMS is finalizing the CY 2026 policies as discussed in this memorandum.

CMS is including 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).

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, 422.256). Organizations are afforded the flexibility to design their benefit packages so long as they satisfy Medicare coverage requirements.

Overview of CY 2026 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 2, 2025, 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 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 Non-EGWP (Excluding 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 2026 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 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 2025 (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 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 2026, 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 2026. 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.

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 applies a TBC evaluation that is designed to protect enrollees from significant increases in cost sharing or decreases in benefits from one year to the next. For 2026, the TBC evaluation will be consistent with the approach used for 2025. 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 adjustment 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 make sure enrollees who continue enrollment in the same plan are not exposed to 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 2026 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 2025 Part C and Part D Baseline OOPC Model values for organizations and posted these values in HPMS (see HPMS memorandum titled "Contract Year 2025 Part C and Part D Baseline Out-of-Pocket Cost Models" issued December 20, 2024). 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, the CY 2026 Bid Review OOPC Models will be released in April 2025. 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 this past year.

As in past years, for 2026, CMS will not evaluate TBC for EGWPs, MSA plans, D-SNPs, and C-SNPs for Chronic Kidney Disease (CKD). EGWP benefit packages are negotiated arrangements between employer groups and MA organizations so CMS believes 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, SNPs for CKD are not effectively addressed by the OOPC model used for the TBC evaluation because the OOPC model cohort includes beneficiaries with and without End-Stage Renal Disease (ESRD) and these plans potentially experience larger increases and/or decreases in payment amounts. These CKD 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.

In response to the "Preliminary CY 2026 Standards for Part C Benefits, Bid Review and Evaluation" memorandum ("preliminary memorandum"), two commenters recommended that CMS treat I-SNPs like D-SNPs by not applying the TBC to these plans, based on the commenters' contentions that the Part D OOPC tool doesn't align with I-SNP benefits and membership and I-SNPs have high dual-eligible enrollment and a unique cost structure. Alternatively, a commenter suggests not applying the TBC test to plans where more than 60% of members have low-income status, since most I-SNP members receive LIS and are not impacted by premium changes.

Unlike D-SNPs, the percentage of dual eligibles as a percent of total enrollment in individual I-SNPs varies widely and non-dually eligible beneficiaries are permitted to enroll in I-SNPs. CMS believes that the TBC evaluation is an important protection for non-dually eligible enrollees in I-SNPs who might otherwise face significant increases in cost sharing or decreases in benefits from one year to the next should CMS choose not to apply the TBC evaluation to I-SNPs. For this reason, CMS will continue to apply the TBC evaluation to I-SNPs in evaluating CY 2026 bids.

Consistent with last year, 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 2026. 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 protects enrollees from significant increases in cost sharing or decreases in benefits, but also ensures enrollees have access to viable and sustainable MA plan offerings.

A commenter recommended changes to the TBC methodology to make a one-time adjustment to account for the 2024 CMS-HCC Model phase-in, suggesting that revenue effects from the risk model changes should be treated similarly to quality bonus payments in the TBC calculations. The commenter encouraged CMS to consider discontinuing TBC altogether, arguing that market competition and existing CMS policies (such as MLR requirements and bid oversight) already provide adequate beneficiary protections.

CMS is concerned that modifying the TBC methodology to account for the 2024 CMS-HCC Model phase-in could potentially impact bid integrity. The plan payment adjustment for CMS' TBC evaluation is based on changes to bid growth, benchmark updates, and star rating changes. Risk scores are not known for the upcoming contract year, and therefore the plan payment adjustment does not make any assumptions for changes in payment related to the risk score. Furthermore, including any adjustment for the phase-in of the risk score model could have an unintended consequence that negatively impacts beneficiaries. For example, if CMS gives all

plans an adjustment for risk score, some plans may no longer be required to reduce costs or increase benefits (or do so at a lesser value), where these plans may actually have the ability to do so due to other aspects of the bidding process and revenue growth from other characteristics of the bid not related to risk scores. For this reason, CMS is not making changes to the TBC evaluation at this time. In addition, CMS is maintaining the TBC evaluation for CY 2026 to make sure enrollees who continue enrollment in the same plan are not exposed to significant increases in cost sharing or decreases in benefits from the prior contract year.

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 enrollee benefits and cost sharing over time. CMS also reminds MA organizations that the CMS Office of the Actuary (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 2026 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 ($185.00).[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 2026 bid submissions. The unweighted average for plans subject to the TBC evaluation, using the 2024 Baseline OOPC models, is about $379 PMPM, compared to about $389 PMPM using the updated baseline OOPC models (a decrease of about $10 PMPM as illustrated in Table 2 below).

In the preliminary memorandum, CMS indicated that the TBC change threshold for the CY 2026 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 $39.00 PMPM or about 10% of the $389.47 Total Beneficiary Cost for the CY 2025 Updated Baseline OOPC Models in Table 2 below. To minimize changes from prior years, as discussed in the preliminary memorandum, CMS is finalizing a TBC change threshold for CY 2026 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. CMS notes that the year-to-year change in the Part B premium amount is accounted for in the technical adjustments discussed previously.

[1] The CY 2026 Part B premium buy-down is limited to the dollar amount of the CY 2025 Part B premium.
[2] See https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf, pages 128-129.

Table 2: TBC Comparison Between CY 2024 and 2025 Baseline OOPC Models
(Unweighted Per Member Per Month Averages)

Item	2024 Baseline OOPC Models	2025 Baseline OOPC Models	Difference
Part C OOPC	$115.21	$125.37	$10.16
Part D OOPC	$93.91	$89.26	($4.65)
Part B Premium	$150.05	$156.08	$6.03
Plan Premium (Parts C&D)	$19.90	$18.77	($1.13)
Total Beneficiary Cost	$379.06	$389.47	$10.42

NOTE: Totals may not equal sum of individual components due to rounding.

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 is including 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 2026 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 2026 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 is providing 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 enrollment-weighted contract-level projected gain/loss margin and 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. CMS followed the methodology in §§ 422.100(f) and (j), 422.101(d), and 422.113(b) to calculate the CY 2026 MOOP limits and cost-sharing standards included in this memorandum. 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.[3] 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

[3] 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.

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.

Per §§ 422.100(f)(4) and (f)(5) and 422.101(d)(2) and (d)(3), CMS calculated three CY 2026 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 CY 2026 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 2026 MOOP and cost-sharing limits discussed in this memorandum (and the calculations for the CY 2024 and 2025 MOOP and cost-sharing limits) are available for reference at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. 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 2026 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 2026 Medicare FFS data projections to calculate the CY 2026 MOOP and cost-sharing limits. This approach remains consistent with the development of the CY 2025 Medicare FFS data projections used to set CY 2025 MOOP and cost-sharing limits. The year(s) of Medicare FFS data and trend factors that the OACT used to develop the CY 2026 Medicare FFS data projections are summarized in the footnotes of the CY 2026 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 2026 MOOP limits. This involved basing calculations on Medicare FFS data projections[4] 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 2026 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 2026 in-network MOOP limits in Table 3 reflect the applicable projected

[4] 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.

Medicare FFS percentiles and the numeric midpoint for the intermediate MOOP type, application of the rounding rules, and 100 percent of ESRD costs.

CMS received three comments pertaining to the CY 2026 MOOP limits. A commenter noted that the preliminary 2026 mandatory MOOP limit is lower than the 2025 mandatory MOOP limit and suggested that this decrease is counterintuitive based on the overall growth rate, the changes seen in the cost-sharing limits for other services from CY 2025 to 2026, and the consistent pattern of increasing MOOP limits over the past several years. Another commenter noted that the CY 2026 mandatory MOOP limit is not increasing to the same degree as the lower MOOP limit and requested CMS explain this phenomenon. Commenters requested that CMS provide more detail or commentary regarding the reason for the decrease to the mandatory MOOP limit from CY 2025 to 2026. A commenter questioned whether CMS included 100% of ESRD costs in the calculations of the CY 2026 MOOP limits. Similarly, another commenter requested CMS provide the ESRD cost breakout in the supporting calculations for MOOP.

Per § 422.100(f)(4)(i) and (f)(4)(v), CMS uses the same general approach to calculate the mandatory MOOP limit since CY 2024. Specifically, CMS increases or decreases the prior year's mandatory MOOP limit for the upcoming contract year to reflect the 95th percentile of the Medicare FFS data projections (that reflect beneficiary out-of-pocket costs for that applicable contract year) and the rounding rules from § 422.100(f)(4)(iii).[5] This calculation is available in the "MOOP limits" tab of the CY 2026 calculation file issued in conjunction with the preliminary memorandum and posted for reference at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. As shown in the CY 2026 calculation file, the CY 2026 mandatory MOOP limit reflects a $100 or about 1% decrease compared to the CY 2025 mandatory MOOP limit. This decrease in the mandatory MOOP limit is a result of a change in the 95th percentile projection from CY 2025 to CY 2026. Small changes to the percentiles of the Medicare FFS data projections are expected annually. However, between CY 2025 and CY 2026, the 95th percentile changed more significantly than lower percentile amounts. Based on the OACT's review, this change to the 95th percentile is primarily due to a large enrollment shift of beneficiaries with ESRD from Original Medicare (Medicare FFS) to MA. It would not necessarily be inconsistent to have a lower 95th percentile, and at the same time have a higher average claim amount for all Original Medicare beneficiaries combined.

CMS confirms that the calculations of the CY 2026 MOOP limits were based on percentiles of projected Medicare FFS beneficiary out-of-pocket cost data that included 100% of cost data from beneficiaries with ESRD. For comparison purposes, CMS added a table that shows the percentile projections for CY 2026 with and without ESRD out-of-pocket costs to the CY 2026 calculation file. For example, as shown in the "MOOP limits" tab of the CY 2026 calculation file CMS used the $9,269 figure to calculate the mandatory MOOP limit (following the methodology at § 422.100(f)(4)(i) and (f)(4)(v) to calculate MOOP limits for CY 2024 and subsequent years) rather than the $8,551 figure which excludes beneficiaries with ESRD.

MA plans must comply with the MOOP limits in Table 3 for CY 2026. Consistent with prior contract years, the PBP module includes validations to prevent an MA organization from

---

[5] Per § 422.100(f)(4)(v), increases to the mandatory MOOP limit are capped at 10% of the prior year's mandatory MOOP limit amount if necessary.

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 $4,200.50 will be considered an intermediate MOOP based on PBP validations applied to that plan's data entry (i.e., $4,200.50 exceeds the $4,200 lower MOOP limit in Table 3).

TABLE 3: FINAL CY 2026 PART C MOOP LIMITS BY PLAN TYPE

Plan Type	Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
HMO and HMO POS	$0 to $4,200 In-network	$4,201 to $6,750 In-network	$6,751 to $9,250 In-network
PPO (Local and Regional)	$0 to $4,200 In-network and $0 to $6,300 Combined	$4,201 to $6,750 In-network and $4,201 to $10,100 Combined	$6,751 to $9,250 In-network and $6,751 to $13,900 Combined
PFFS (full, partial, and non-network)	$0 to $4,200	$4,201 to $6,750	$6,751 to $9,250

Cost-Sharing Standards

To calculate the CY 2026 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 2026 Medicare FFS data projections to calculate the inpatient hospital cost-sharing limits, but for the inpatient hospital acute and psychiatric 60-day length of stay scenario and lower MOOP type, the results exceeded the Part C lower MOOP amount. In these cases, CMS capped the cost-sharing limit at the lower MOOP amount from Table 3.

CMS received one comment on the CY 2026 inpatient hospital cost-sharing limits. This commenter expressed concerns regarding whether 100% of ESRD costs were incorporated into the calculations and asked for additional detail to be provided, including breakouts showing the differences to projected Part B professional cost-sharing values with and without ESRD costs and an explanation for the decrease to inpatient hospital acute Part B services observed from 2023 to 2024.

CMS confirms that the data used to calculate the inpatient hospital acute and psychiatric service category cost-sharing limits for CY 2026 included 100% of ESRD costs per § 422.100(f)(4)(vi)(B) and (f)(6)(iv)(C)). These calculations are available in the "Inpatient Hospital Acute" and "Inpatient Hospital Psychiatric" tabs of the CY 2026 calculation file issued in conjunction with the preliminary memorandum and posted for reference at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. For clarity on the impact of ESRD costs in these calculations, CMS added a table that shows the projected Part B professional cost-sharing values for an inpatient acute hospital without ESRD costs to the CY 2026 calculation file.

As the commenter noted, the projected Part B professional cost-sharing values (with ESRD costs) for a 10-day inpatient hospital acute length of stay decreased in 2024. CMS confirms that the projected Part B professional day cost-sharing values used to set the inpatient hospital acute

and psychiatric service category cost-sharing limits from CY 2024 through CY 2026 included 100% of ESRD costs. The OACT projected this decrease based on data from several years prior to the projection year which suggested utilization changes, including the effects of COVID, significant enough to result in this decrease.

To calculate the CY 2026 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 2026 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)) or the value for that service category resulting from the actuarially equivalent copayment transition specified in § 422.100(f)(8)(ii). For CY 2026, the transition to actuarially equivalent copayments beginning with contract year 2023 limits concludes with the actuarially equivalent copayment differential in the calculations of copayment limits increasing from 75 percent for CY 2025 to 100 percent for CY 2026 (§ 422.100(f)(8)(ii)(D)).

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.

Beginning January 1, 2024, Medicare started allowing marriage, family, and mental health counselors to bill independently for their professional services and made changes to payment for certain mental health specialty services, including services involving community health workers and outpatient psychotherapy for crisis services. Based on this, CMS expanded the list of provider specialties used to set the CY 2026 copayment limits for this service category to include covered services marriage, family, and mental health counselors and new payment rates for certain mental health specialty services. However, the inclusion of these new provider specialties did not meaningfully impact the copayment limits for this category for CY 2026. MA plans must apply the "mental health specialty services" service category cost-sharing limits shown in Table 4 to the expanded list of professional types allowable for these specialty services covered during CY 2026.

Beginning January 1, 2024, Medicare also started covering and paying for Intensive Outpatient Program (IOP) services. IOP services provide a less intensive therapy treatment than under the partial hospitalization program. For CY 2026, CMS set cost-sharing limits specific to IOP services that are separate from the cost-sharing limits appliable to partial hospitalization program services in Table 4 and established separate data entry for this benefit in the PBP module.

On December 10, 2024, CMS released a proposed rule titled, "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" (89 FR 99340). In this proposed rule, CMS proposed to make cost sharing no greater than Original Medicare for behavioral health service categories beginning with CY 2026. These service categories included: inpatient hospital psychiatric services, mental health specialty services, psychiatric services, partial hospitalization, outpatient substance abuse services, and opioid treatment program services. At this time, CMS has decided not to implement this proposal for CY 2026 and the cost-sharing limits shown in Table 4 for those categories[6] are final for CY 2026.

Table 4 below summarizes the standards and maximum permissible cost-sharing amounts by MOOP type under § 422.100(f)(6), (f)(7), (f)(8), and (j)(1); CY 2026 bids must reflect enrollee cost sharing for in-network services no greater than the amounts displayed below. These standards will be applied only to in-network Parts A and B services unless otherwise indicated in the table. 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 2026 IN-NETWORK SERVICE CATEGORY COST-SHARING LIMITS

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
Inpatient Hospital – Acute – 60 days[1]	1a	$4,200	$5,185	$6,171
Inpatient Hospital – Acute – 10 days[1]	1a	$3,401	$3,061	$2,721
Inpatient Hospital – Acute – 6 days[1]	1a	$3,056	$2,751	$2,445
Inpatient Hospital – Acute – 3 days[1]	1a	$2,787	$2,509	$2,230
Inpatient Hospital Psychiatric – 60 days[1]	1b	$4,200	$3,790	$3,380
Inpatient Hospital Psychiatric – 15 days[1]	1b	$2,819	$2,537	$2,255
Inpatient Hospital Psychiatric – 8 days[1]	1b	$2,600	$2,340	$2,080
Skilled Nursing Facility – First 20 Days[3]	2	$20/day	$10/day	$0/day
Skilled Nursing Facility – Days 21 through 100[3]	2	$218/day	$218/day	$218/day
Cardiac Rehabilitation[4]	3-1	50% / $50	40% / $40	30% / $30
Intensive Cardiac Rehabilitation[4]	3-2	50% / $65	40% / $50	30% / $40
Pulmonary Rehabilitation[4]	3-3	50% / $40	40% / $35	30% / $25
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)[4]	3-4	50% / $30	40% / $25	30% /$20
Emergency Services[4,5]	4a	$150	$130	$115
Urgently Needed Services[4,5]	4b	50% / $65	40% / $50	30% / $40
Partial Hospitalization Program[4]	5a	50% / $175	40% / $140	30% / $105
Intensive Outpatient Services[4]	5b	50% / $180	40% / $145	30% / $110
Home Health[2]	6	20% / $45[4]	$0	$0
Primary Care Physician[4]	7a	50% / $70	40% / $55	30% / $40
Chiropractic Care[4]	7b	50% / $20	40% / $15	30% / $15
Occupational Therapy[4]	7c	50% / $60	40% / $50	30% / $35

[6] Per § 422.100(f)(6)(i), the cost-sharing limits for outpatient substance abuse services and opioid treatment program services are 50% coinsurance for all MOOP types and are excluded from Table 4.

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
Physician Specialist[4]	7d	50% / $95	40% / $75	30% / $55
Mental Health Specialty Services[4]	7e	50% / $85	40% / $70	30% / $50
Psychiatric Services[4]	7h	50% / $90	40% / $70	30% / $55
Physical Therapy and Speech-language Pathology[4]	7i	50% / $95	40% / $75	30% / $55
Therapeutic Radiological Services[2,4]	8b2	20% / $85	20% / $85	20% / $85
DME-Equipment	11a	50%	50%	20%[2,4]
DME-Prosthetics	11b1	50%	50%	20%[2,4]
DME-Medical Supplies	11b2	50%	50%	20%[2,4]
DME-Diabetes Monitoring Supplies[6]	11c1	50%	50%	20%[2,4]
DME-Diabetic Shoes or Inserts	11c2	50% / $30	50% / $30	20% / $10[2,4]
Dialysis Services[2,4]	12	20% / $70	20% / $70	20% / $70
Part B Drugs-Insulin[7]	15-1	$35	$35	$35
Part B Drugs-Chemotherapy/Radiation[2,4,8]	15-2	20% / $395	20% / $395	20% / $395
Part B Drugs-Other[2,4,8]	15-3	20% / $340	20% / $340	20% / $340

[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 and psychiatric 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 2026 cost-sharing limit for the inpatient hospital acute and psychiatric 60-day length of stay at the lower MOOP limit for these scenarios.

[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 2026. 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] Cost-sharing limits for these service categories (and for the DME service categories for MA plans with the mandatory MOOP type) are subject to the multiyear transition schedules finalized in §§ 422.100(f)(6)(iii), (f)(8), (j)(1)(ii), and 422.113(b)(2)(v).

[5] 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) (which includes being subject to the transition limits in § 422.100(f)(8)), per § 422.113(b)(2)(vi).

[6] CMS did not set a copayment limit for "DME – diabetes monitoring supplies" based on large variations in cost from year-to-year due to the monitoring supplies PBP service category including items with high and very low costs together. CMS is considering separating this category into two categories in a future contract year to address this issue.

[7] 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.
[8] 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 2026 > 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 2026, 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 2025. 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 2025.

TABLE 5: ILLUSTRATIVE COMPARISON OF SERVICE-LEVEL ACTUARIAL EQUIVALENT COSTS TO IDENTIFY EXCESSIVE COST SHARING FOR CY 2026

	#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	1.308	$33.09	$0.40	Fail
SNF	$10.83	$58.19	$9.89	1.069	$10.57	$0.26	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 2026 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) 2026 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 memo.

For CY 2026 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 2025 plan will be compared independently to the CY 2026 plan.
- Segmenting an existing plan: TBC for each CY 2026 segmented plan will be compared independently to the CY 2025 non-segmented plan.
- Consolidating/crosswalking previously segmented plans into one non-segmented plan: TBC of each existing CY 2025 segmented plan will be compared independently to the non-segmented CY 2026 plan.
- Consolidating/crosswalking segmented plans into other segmented plans: TBC of each existing CY 2025 segmented plan will be compared independently to the segmented CY 2026 plan.

If CMS provides the MA organization an opportunity to address CY 2026 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 a 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 2025 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 2026 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 2025 ($174.70) and the amount for CY 2026 ($185.00)	Value is $10.30 for all plans
	L	Impact of changes in OOPC Model between CY 2025 and CY 2026	Plan-specific value will be provided by CMS through an HPMS posting
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 2025 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 2025 BPT. MA organizations will be able to calculate their plan-specific CY 2026 OOPC value (Item D) and combine that with their proposed Premium (net of rebates) for CY 2026 (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 2025 and CY 2026 (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 2025 and CY 2026 (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.[7] 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

[7] 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.

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 2026 rebate minus the CY 2025 rebate. The CY 2025 Bid Amount and Benchmark are taken from the plan-submitted CY 2025 Bid Pricing Tool (BPT). For purposes of the illustrative calculation below, the CY 2025 Bid Amount is assumed to grow by the same MA growth percentage as was used to develop the CY 2025 ratebook. The CY 2026 Benchmark is the weighted average of county-specific payment rates using the CY 2026 ratebook and projected enrollment from the CY 2025 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

	-1 Values					Values							
Bid ID	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium*	Star Rating	Bid Amt.	Benchmark	Rebate %	Rebate or Premium *	Rebate Difference	Payment Adj.	TBC Threshold
Plan 001	3	$1,000.00	$950.00	50%	($50.00)*	3	$1,107.20	$1,051.84	50%	($55.36)*	($5.36)	($5.36)	$45.36
Plan 002	3	$1,000.00	$1,050.00	50%	$25.00	3	$1,107.20	$1,162.56	50%	$27.68	$2.68	$2.68	$37.32
Plan 003	3	$1,000.00	$1,300.00	50%	$150.00	3.5	$1,107.20	$1,439.36	65%	$215.90	$65.90	$40.00	$0.00
Plan 004	3.5	$1,000.00	$1,500.00	65%	$325.00	3	$1,107.20	$1,660.80	50%	$276.80	($48.20)	($40.00)	$80.00
Plan 005	3.5	$1,000.00	$1,300.00	65%	$195.00	4	$1,107.20	$1,504.36	65%	$258.15	$63.15	$40.00	$0.00
Plan 006	4	$1,075.00	$1,100.00	65%	$16.25	3.5	$1,190.24	$1,162.92	65%	($27.32)*	($43.57)	($40.00)	$80.00
Plan 007	2.5	$1,000.00	$1,300.00	50%	$150.00	2.5	$1,107.20	$1,250.00	50%	$71.40	($78.60)	($40.00)	$80.00

*Indicates that the amount is a premium.
Note: Slight variances in numbers are due to rounding.

Illustrative Calculation Descriptions

a. Plans 001 through 004 have benchmark growth of 10.72%.
b. Plan 001 bid amount is greater than the benchmark in both years (and Plan 006 in 2026); 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. For 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 10.72% 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 10.72% less 5.0% to simulate losing a bonus payment; therefore the payment adjustment is minimized at -$40 PMPM.
h. Plan 007 has a 2026 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 2026 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
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 2026 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 2026 > Plan Benefit Reports > Service Category Report and Plan Bids > Bid Reports > CY2026 > Plan Benefit Reports > Medicare Benefit Description Report).

Out of Network Benefits

Out of Network (OON) cost-sharing questions and separate OON notes fields have been added to the PBP "Benefit Details" screens for any benefits that may be offered OON. In previous years, the OON data entry was located in the PBP under "Cost Share Groups." Plans should complete the OON cost-sharing data entry on the "Benefit Details" screens under each applicable service category. In accordance with 42 CFR 422.100(o), OON cost-sharing rules for D-SNP PPOs have been applied. Point-of-Service (POS) Group functionality remains in place under "Cost Share Groups."

Partial Hospitalization/Intensive Outpatient Program (IOP) Services

PBP service category 5: Partial Hospitalization has been renamed "Partial Hospitalization/Intensive Outpatient Program Services" and is now split into two distinct sub-categories: Partial Hospitalization (5a) and Intensive Outpatient Program Services (5b). MA plans should enter cost sharing and notes in each of the new sub-categories.

Removal of 14e3: Barium Enema

Effective January 1, 2025, Medicare FFS removed coverage of barium enema as a method of colorectal cancer screening as part of the CY 2025 Physician Fee Schedule (PFS) Final Rule.[8] As a result, the Medicare-covered preventive service PBP service category 14e3: Barium Enema has been removed.

Special Supplemental Benefits for the Chronically Ill (SSBCI) Chronic Conditions

In SSBCI 19a: Reduction in Cost Sharing and 19b: Additional Benefits packages, the list of chronic conditions available for selection has been updated to be consistent with the list included 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). MA plans offering SSBCI packages also retain the ability in the PBP to enter up to five (5) "other" chronic conditions.

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.

[8] See 89 FR 97710, "CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments" https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

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. In general, MA plans should only enter the single, combined maximum plan benefit amount in the CSB group, 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.

There are a few exceptions where plans should duplicate the combined maximum plan benefit amount in the benefit category:

- ***Dental/Vision/Hearing***: Plans with a combined maximum amount for Diagnostic and Preventive Dental (16b) and Comprehensive Dental (16c) will create a CSB group, select the 16b and 16c service categories, and enter the shared maximum amount on the CSB screen. Under Benefit Details, plans should duplicate the shared maximum amount on the 16b screen and select "Covered under Diagnostic and Preventive Dental (16b)" for the maximum plan benefit coverage type on the 16c screen. This exception also applies to plans with a combined maximum amount for Eye Exams (17a)/Eyewear (17b) or Hearing Exams (18a)/Prescription Hearing Aids (18b). Plans should duplicate the shared maximum amount in the CSB group and "Benefit Details" sections for 17a/b and/or 18a/b.

- ***Extending a Base Benefit Maximum to MA Uniformity Flexibility (MA-UF) or SSBCI***: Plans with a maximum plan benefit amount for a base package supplemental benefit (under "Benefit Details") that want to extend the same maximum plan benefit amount to a MA-UF or SSBCI benefit for eligible enrollees will create a CSB group, select the base package benefit and additional benefit for either MA-UF or SSBCI, and enter the shared maximum amount within the CSB group. Plans will duplicate the shared maximum amount within the Benefit Details section for the base package benefit, but the plan will enter a $0 maximum amount for the MA-UF/SSBCI benefit.

Additional examples of CSB groups and detailed data entry instructions are described in the CY 2026 PBP User Guide within HPMS (Navigation Path: Plan Bids > PBP > Documentation > PBP CY2026 User Guide).

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.

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 is 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, visit/trip limit and list of combined benefit categories are captured in the data entry and need not be repeated in the notes unless necessary for clarity. 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).”
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.”

Category/Circumstance	Information required in the note
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 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 services covered. The mention of a gym/fitness club membership, or a nationally recognized program, is sufficient. Otherwise, a description of the type of physical fitness benefit must be included. If the purchase of fitness equipment is covered, a list of the equipment must be included in the note. Physical fitness benefits in this category must not include social events, general use items such as fitness apparel, sneakers, or merchandise or 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."
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 ADLs/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).

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/.

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[9] 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, 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)[10] 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.

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

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

plan's PBP. Further, as stated in the January 2021 Final Rule[11] (86 FR 5971), 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. 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

MA plans may administer reductions in cost sharing for covered benefits and/or covered supplemental benefits, or combinations of supplemental benefits with a shared maximum benefit amount through a debit card. The PBP must identify the covered benefits or reductions in cost sharing that are facilitated through use of the debit card. Consistent with this, all the items and services for which payment may be made (in the form of a reduction in cost sharing that would otherwise apply for the item or service or in the form of the MA plan's payment of its share of the amount owed to the provider) must meet the requirements to be a supplemental benefit. Plans are reminded that as stated in the 2021 Final Rule (86 FR 5864, p. 5913) they are expected to administer benefits in a manner that ensures the debit card and/or allowance can only be used towards plan-covered items and services. Plans are also reminded that the debit card is not a covered benefit but the mechanism by which the MA plan provides payment to providers for the covered benefit.

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.

[11] https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf

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.