



MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: February 21, 2025

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

FROM: Kathryn A. Coleman
Director

SUBJECT: Preliminary Contract Year 2026 Standards for Part C Benefits, Bid Review and Evaluation

This memorandum includes preliminary 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. Final instructions and guidance are anticipated to be issued in an HPMS memorandum in April 2025.

CMS is providing interested parties an opportunity to comment on aspects of contract year (CY) 2026 benefits standards, bid evaluation standards and instructions with this memorandum.

Comments on this memorandum and related materials may be submitted electronically to: PartCComments@cms.hhs.gov. Please ensure each comment references the memorandum's section title and page number to which the comment pertains (please also include tab name and specific item description for any materials related to Part C maximum out-of-pocket (MOOP) and cost-sharing calculations in the supporting spreadsheets described in the "Part C maximum out-of-pocket limits and cost-sharing standards overview" section in this memorandum).

Comments will be made public, so submitters should not include any confidential or personal information. To receive consideration prior to finalizing this memorandum in advance of bid submission, comments must be received by 6:00 PM Eastern Time on March 24, 2025. Because of the volume of public comments, we are not able to acknowledge or respond to comments individually.

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)).

Medicare-Medicaid Plans in a capitated model under the Medicare-Medicaid Financial Alignment Initiative are not subject to the review criteria summarized in the table below and benefit review information for these plans will be provided separately.

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 notice may depend on the type and/or severity of error(s).

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

Table 1: Applicable Bid Review Criteria by Plan Type

Bid Review Criteria	Applies to Non-EGWP (Excluding Dual Eligible SNPs)	Applies to Dual Eligible SNPs	Applies to Section 1876 Cost Plans	Applies to EGWP Plans¹
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

¹Employer 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.

²Section 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 memo, 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

At the end of March 2025, CMS expects to notify 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, will 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).

MA organizations receiving this notification must either (1) confirm 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) provide a justification to CMS for renewal. If CMS finds that the low enrollment justification is insufficient, CMS will instruct 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 will be 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 will consider 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 will use the same TBC evaluation as in past years to calculate the TBC change amount as described below. 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 End Stage Renal Disease (ESRD) Requiring Dialysis. EGWP benefit packages are negotiated arrangements between employer groups and MA organizations so we believe that the employer would have taken these costs into account in making such plans available. MSAs have unique benefit designs that include a medical savings account for purposes of paying for Part A and B benefits costs before the enrollee meets the deductible. D-SNP PBP data entry does not include the additional state benefits and cost-sharing relief that dually eligible beneficiaries will have in that plan. These factors prevent the TBC evaluation (that uses PBP data) from reflecting the full benefit and cost-sharing package available to enrollees in D-SNPs. Finally, SNPs for the chronic condition of ESRD requiring dialysis are not effectively addressed by the OOPC model used for the TBC evaluation because the OOPC model cohort includes beneficiaries with and without ESRD and these plans potentially experience larger increases and/or decreases in payment amounts. These ESRD C-SNPs are subject to all other MA standards and CMS will

contact plans if CMS identifies large benefit or premium changes (while taking into consideration payment changes) during bid review.

Consistent with 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.

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 OACT extends flexibility on gain/loss margin requirements so MA organizations can satisfy the TBC standard.

In mid-April 2025, 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). 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 the table below. To minimize changes from prior years we are setting the 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. We note 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. 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 expects to provide detailed TBC information and examples of how the TBC evaluation will be applied to consolidating or crosswalking plans prior to bid submission.

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. 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 have not explicitly been waived by CMS, regardless of whether they are affirmatively evaluated as part of bid review or in connection with other reviews.

CMS followed the methodology in §§ 422.100(f) and (j), 422.101(d), and 422.113(b) to calculate the CY 2026 MOOP limits and cost-sharing standards included in this memorandum. Per § 422.100(f)(7)(iii), this memorandum provides advance public notice of and announces the available comment period for the projected CY 2026 MOOP limits and cost-sharing standards. This memorandum is issued now to allow sufficient time for a comment period, consideration of

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>.

comments, and issuance of final MOOP limits and cost-sharing standards for CY 2026 early enough for MA organizations to prepare and submit plan bids.

Per §§ 422.100(f)(4) and (f)(5) and 422.101(d)(2) and (d)(3), CMS calculates three in-network and combined MOOP limits using Medicare fee-for-service (FFS) data projections (as shown in Table 3). For each in-network MOOP type CMS also calculates corresponding in-network service category specific cost-sharing limits (as shown in Table 4). An A 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 reference calculations for the CY 2024 and 2025 MOOP and cost-sharing limits) are available for review at: <https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics>. In this memorandum and the related CY 2026 calculation files, we identify and, as necessary, explain substantive differences in calculating MOOP limits and cost-sharing standards compared to the methodology used for CY 2025 requirements, such as finishing the transition for service category cost-sharing standards beginning with CY 2023 and ending in CY 2026 per § 422.100(f)(8)(ii). If your comment pertains to the CY 2026 calculation file, please reference the spreadsheet tab name(s), table number(s), and cell number(s) (e.g., cell A1), if applicable.

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 projections⁴ 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 Medicare FFS percentiles and the numeric midpoint for the intermediate MOOP type, application of the rounding rules, and 100 percent of ESRD costs.

MA plans must comply with the MOOP limits in Table 3 for CY 2026. Consistent with prior contract years, the PBP module includes validations to prevent an MA organization from entering MOOP and cost-sharing amounts that are above the MOOP and cost-sharing limits for the year, while also allowing plans to have MOOP and cost-sharing amounts that are not rounded to a whole dollar amount. For example, an HMO plan that establishes an in-network MOOP amount of \$4,150.50 will be considered an intermediate MOOP based on PBP validations applied to that plan's data entry (i.e., \$4,150.50 exceeds the \$4,150 lower MOOP limit in Table 3).

TABLE 3: 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.

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

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.

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. The OACT did not have sufficient utilization data available for these services to incorporate their costs into the projected weighted average allowed amount for the CY 2025 “mental health specialty services” service category standard used for setting MA cost-sharing limits. As a result, the same provider specialties used to set the CY 2024 copayment limits were used to calculate the CY 2025 copayment limits for the “mental health specialty services” service category, including clinical psychologist, licensed clinical social worker, and psychiatry. At this time, sufficient utilization data is available to expand 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.. The OACT did not have sufficient utilization data available for this service type to project a CY 2025 allowed amount for these IOP services that is separate from partial hospitalization program services. As a result, the CY 2025 cost-sharing limit for partial hospitalization services also applied to the IOP services furnished during CY 2025. For CY 2026, CMS set cost-sharing limits specific to IOP services that are separate from the cost-sharing limits applicable to partial hospitalization program services in Table 4 and is establishing 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). The cost-sharing limits shown in Table 4 for those categories are subject to a final rule for that proposal.

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); if finalized 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: 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
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

Service Category	PBP Data Entry Field	Lower MOOP	Intermediate MOOP	Mandatory MOOP
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)(I). 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 Amount² (#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 preliminary 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. Comments on this memorandum and related materials may be submitted electronically to: PartCComments@cms.hhs.gov by 6:00 PM Eastern Time on March 24, 2025. CMS will consider comments submitted by this deadline before issuing final instructions and guidance in an HPMS memorandum in April 2025.

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.