

User Group Call Date 02/19/2026

Introductory note

- For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
 For COVID-19 policy and benefit related questions: <https://ma-covid19-policybenefits.lmi.org/covid19mailbox>
 For Part C policy-related payment questions: PartCpaymentpolicy@cms.hhs.gov
 For Part C policy-related questions (including OOPC/TBC policy): <https://mabenefitsmailbox.lmi.org/>
 For Part D policy-related questions: partdpolicy@cms.hhs.gov
 For Part D benefit-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
 For questions related to risk score models and released data: riskadjustmentpolicy@cms.hhs.gov
 For questions related to the Encounter Data Processing System: riskadjustmentoperations@cms.hhs.gov
 For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
 For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
 For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
 For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rates	01/28/2026 13:26	2027 340b Reduction Assumption in CY2027 Advance Notice	<p>The 2026 OPSS Final Rule implemented the original 0.5%, recoupment of 340b lump sum payments but stated intentions to have a larger reduction in 2027.</p> <p>The trends supporting 2027 AN growth rates file shows on page 4 in the Outpatient Hospital Trend section a 2026 unit cost trend of 2.6% and a 2027 trend of 2.3%. Does the 2026 trend of 2.6% includes the 0.5% reduction for 340b recoupment? Does the 2027 trend of 2.3% include any additional reduction?</p> <p>If 2027 doesn't have additional 340b reductions built in, what are the other factors that are bringing the trend below any value since 2022?</p>	<p>The published outpatient unit cost trends for 2026 and 2027 exclude the effects of the 340b recoupment.</p> <p>Additionally, the update for 2027 is lower than for 2023–2026 because the projected market basket update for 2027 is relatively low, while the projected productivity offset is relatively high.</p>
2	Growth Rates	01/28/2026 13:45	2026 Physician Fee Schedule Trend in CY2027 AN	<p>The 2026 PFS Final Rule announced modest fee updates, APM updates separate for qualifying and non-qualifying providers, and the 2.5% “doc fix” from the One Big Beautiful Bill, among other factors. It also mentioned an RVU efficiency adjustment of -2.5%.</p> <p>I was surprised to see in the trends supporting 2027 AN growth rates on page 4 under Physician Fee Schedule Trend that the unit cost trend for 2026 is 2.96%. I would have guessed something closer to 1.0%. Please explain.</p> <p>Additionally, is the 2026 RVU impact reflected in the published unit cost trend? Further, does the RVU impact to net out to something close to zero or something else?</p>	<p>The One Big Beautiful Bill Act (OBBA) implemented a 2.5% update to the conversion factor for 2026. This is on top of the 0.75% update for physicians in alternative payment models (APMs) and 0.25% for physicians not in APMs (full updates are roughly 3.27% and 2.76%). The unit cost trend of 2.96% is the weighted average of the updates and we assume that 40.1% of physician fee schedule (PFS) spending is in APMs.</p> <p>Additionally, the impact of the RVU impact is not reflected in the published unit cost trend, but is accounted for in the conversion factor.</p> <p>The Fact Sheet to the CY 2026 Medicare Physician Fee Schedule Final Rule addresses the impact of the RVU on physician payments. That is, under the CY 2026 PFS Rate Setting and Conversion Factor section of the fact sheet, “The changes to the PFS conversion factors for CY 2026 include these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated +0.49 percent adjustment necessary to account for finalized changes in work RVUs for some services.”</p>

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
3	Growth Rates	Various	N/A	Can you provide more information on the 2027 Advance Notice impact of the skin substitute provisions of the 2026 physician fee schedule regulation? In particular, please provide projected skin substitute spending reflected in both the 2026 Rate Announcement and the 2027 Advance USPPCs. Additionally, what trend is assumed for physician administered drugs excluding skin substitutes?	<p>As referenced, spending for skin substitutes are included in physician administered drug category in our published non-ESRD FFS USPPC trend exhibits. As shown in the 2027 Advance Notice trend exhibit, physician administered drug USPPCs changed by -21.7% for 2026 and -21.9% for 2027 relative to the 2026 Rate Announcement. The impact of this update on the 2027 Advance Notice non-ESRD FFS USPPCs is -1.88% in 2026 and -1.94% in 2027.</p> <p>Also, total (non-ESRD and ESRD) skin substitute spending by calendar year and baseline is as follows (in billions):</p> <ul style="list-style-type: none"> • 2023: \$3.3 2026 RA and 2027 AN • 2024: \$7.9 2026 RA, and \$7.6 2027 AN • 2025: \$9.7 / \$13.4 • 2026: \$9.6 / \$0.5 • 2027: \$10.4 / \$0.5 <p>Additionally, the projected per capita trend in PA drugs excluding skin substitutes is 8.0% for both 2026 and 2027.</p>

User Group Call Date 04/16/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	02/27/2026 9:11	RE: Questions on Part B Rx underlying the growth rate	Please clarify how the projected trend was developed in the 2027 Advance Notice USPPCs for physician administered drugs, excluding skin substitutes.	The physician-administered drug spending projection is based on an analysis of historical physician-administered drug spending.
2	FFS Trends	02/18/2026 0:00	FFS Trends - Categorization Question	Does CMS (OACT) release any information as to how claims are categorized within the "Trends Supporting 2027 AN Growth Rates" report? I am particularly interested in how certain drug expenses are classified between Outpatient Hospital and Physician Administered Drugs, and would appreciate any information you could share on your claims categorization more generally. Also, can you provide any information as to what is included in the large "Other" category in Outpatient Hospital trends in 2022 and 2023?	The Part B spending category is based on which payment system the claim is paid through. For Part B drugs, this is typically related to the place of service. The unit cost line in the trend exhibit captures price changes for non-drug services but excludes price changes for drug services. Price trends for outpatient drugs are instead embedded within the "other" trend category. This component is the primary driver of the "other" trend in 2022 and 2023. Another key contributor to the "other" trend is legislative changes, particularly those affecting 340B drugs.
3	USPPCs	03/30/2026 13:06	USPCC projection	Could you please confirm whether OACT considered the phase-out impact of the inpatient only list in 2026-2027 cost projections?	The projections are based on the historical experience which includes shifting of services from inpatient to outpatient, and from outpatient to ASC. We assume that a similar pace of shifting will continue to occur in the future. There is not a factor to explicitly account for the phase-out of the inpatient only list.
4	Supporting Documentation	02/27/2026 13:37	Question Regarding Appendix B, Section 21.1 of the MA BPT Instructions	(Paraphrased) We are seeking clarification regarding the reporting requirements outlined in Appendix B, Section 21.1 of the MA BPT Instructions for non-covered services (Worksheet 2, lines 1 through q, column o). Specifically, we are seeking guidance on the appropriate method for providing the required benefit-level support and PMPM breakdowns in instances where benefits are delivered through capitated arrangements or where services are not priced at the detailed granularity described in Section 21.1. In such cases, the underlying cost data may not be readily available at the individual benefit or subcategory level. For example, allowance benefits are each priced for the allowance as a whole using a pricing model that projects the total spend out of the total available allowance without creating an allocation of the projected spend by the qualifying items.	In these circumstances, it is acceptable to report benefits and PMPMs by the granularity at which they are priced, consistent with the amounts reflected in the BPT. However, additional documentation that explicitly outlines the benefits included in the capitated amount (consistent with the new Appendix B.21.2 guidance), as well as any applicable any bid IDs, must also be included in the plan's Appendix B.21 support.
5	Rebate Reallocation	04/09/2026 10:24	Rebate Reallocation Permissibility – Partial Return to Premium	(Paraphrased) Does Example 2 from the February 2026 User Group Call on rebate reallocation, along with the updated CY2027 Appendix E, Section 10.1.1, conflict with Case #3 of Table A in Appendix E? Specifically, Case #3 of Table A implies that if a plan has a negative Part D basic premium with \$0 allocated toward the Part D basic premium in the initial submission, and the post-benchmark release total Part D premium is greater than \$0, the plan is not permitted to participate in rebate reallocation. However, the CY2027 updates to Section 10.1.1 and Example 2 from the February 2026 User Group Call appear to suggest that, in this scenario, a plan may move rebates away from the Part D supplemental premium at rebate reallocation in order to return to its initially intended total Part D premium, which would require the plan to be permitted to participate in rebate reallocation. Which interpretation is correct?	In this scenario, the plan is permitted to participate in rebate reallocation, as described in Section 10.1.1 and the February 2026 User Group Call. The rebate reallocation tool reflects this permissibility in both the prior year's version and the upcoming CY2027 version. Additionally, the updated CY2027 tool will incorporate any Part D supplemental premium rebates into the unallocated rebate amount used for reallocation, allowing the plan to return to its initially intended total Part D premium. Regarding permissibility, the tool will only trigger Case #3 of Table A in Appendix E when Line 7c is less than or equal to Line 7a (where Line 7a reflects the published benchmarks). Therefore, Case #3 does not apply to plans with a negative Part D basic premium at the time the published benchmarks are released, since \$0 will always be greater than a negative value. We recognize that the current wording in the BPT instructions does not clearly address this scenario. Future guidance will be updated to better reflect this nuance.
6	Insulins	02/18/2026 1:37	Part D Insulin Cost Sharing Question	For the 2026 and 2027 plan years, are DS plans allowed to offer cost sharing for insulins that is less than the minimum of: \$35, 25% of negotiated price, or 25% of MFP price consistent with the 2024 and 2025 Part D Redesign Program Instructions, and of section 11406 of the IRA? If DS plans do have the flexibility to offer lower cost sharing, would it then be appropriate to include the cost of the lower cost sharing as part of the basic bid in the Part D BPTs? If so, and a plan determines that an induced utilization factor is appropriate to account for the impact of lowering insulin cost sharing, should that induced utilization impact flow into the basic bid? Also, if the reduced cost sharing should be reflected in the basic bid, would this also apply to EA plans? That is, should EA plans with reduced cost sharing for insulins reflect that lower cost sharing as part of the basic bid, or is that only applicable to DS plans?	The basic benefit on insulins is any amount below the limit. Therefore, the DS plan is allowed to have cost sharing below the maximum. The trend for this benefit should be captured in worksheet 2 since it is induction under the basic benefit. This also applies to EA plans. We also note that the insulin benefit is excluded from equivalence testing.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Excepted Drugs	N/A	N/A	<p>Our Plan had a six tier formulary in the base period with tier 5 (specialty drugs) indicated as the tier utilized for scripts filled as an exception. For CY2027, the formulary reflects five tiers with the exception tier remaining as tier 5 (specialty drugs). The scripts filled in the base period as an exception are reported on tier 5 and flagged as specialty for the purposes of modeling and populating the BPTs. There are drugs filled as an exception that would not be considered specialty drugs. Can we just apply specialty trends to this tier and keep them in specialty for the projection period?</p>	<p>Specialty trends should not be applied to these excepted drugs that are not specialty drugs. Plans should apply the appropriate drug type trend of the excepted drug (i.e. non-preferred brand). Similarly, these drugs should be reported in the base period and projection period under the appropriate drug type.</p>
8	Maximum Fair Price Drugs	03/20/2026 23:45	Clarification on Interpretation of 2027 Part D MFP Drug Definition in BPTs	<p>The 2027 Part D instructions define MFP drugs as “those drugs which were selected for negotiation for initial price applicability for CY2027.” We would appreciate clarification on how this definition should be interpreted for purposes of populating the MFP sections of the BPTs.</p> <p>Specifically, should the MFP sections include only drugs that were newly selected for MFP with initial price applicability in 2027, or should they also include drugs that were selected for MFP in prior years and remain subject to MFP in 2027?</p> <p>To frame the question, we are considering the following scenarios:</p> <ol style="list-style-type: none"> Scenario 1 (IPAY 2026): A drug was an MFP drug in 2026 and continues to be an MFP drug in 2027. Scenario 2 (IPAY 2026): A drug was an MFP drug in 2026 but was removed from the MFP list for 2027 (e.g., Entresto, Xarelto, and Stelara). Scenario 3 (IPAY 2027): A drug was not an MFP drug in 2026 but is selected for MFP with initial price applicability in 2027. <p>Guidance on how each of these scenarios should be reflected in the MFP sections of the BPTs would be helpful.</p>	<p>There are three places in the Part D BPT where the plan sponsor must break out experience for MFP drugs. This includes drugs that were selected for MFP in prior years and remain subject to MFP in the BPT Worksheet’s given year (either base or projection period).</p> <ol style="list-style-type: none"> First, on Worksheet 1, Section VI, plan sponsors must enter the total number of scripts, allowed dollars, and cost sharing for MFP drugs. In this section, MFP drugs are defined as those drugs which were on the MFP drug list for the base year. These drugs could have been selected for initial price applicability in the base year or in prior years. For CY2027 bids, this would be CY2025 and prior. Since there were no negotiations prior to CY2026, these cells are currently inactive. Second, on Worksheet 2, Section II, columns E and F (cells E24 and F24), plan sponsors must enter the number of scripts per 1,000 and allowed per scripts in the base year (2025) for MFP drugs. In this section, MFP drugs are defined as the drugs that will be on the MFP drug list for the projection year. These drugs could have been selected for initial price applicability in the projection year or in prior years. For CY2027 bids, this would be CY2027 and prior. The trends entered in Worksheet 2, Section III, should be the two-year trends to project the base-period experience of these drugs to the projection period. Lastly, on Worksheet 3, Section IV, plan sponsors must enter the total number of scripts, allowed dollars, and cost sharing for MFP drugs. In this section, MFP drugs are defined as the drugs that will be on the MFP drug list for the projection year. These drugs could have been selected for initial price applicability in the projection year or in prior years. For CY2027 bids, this would be CY2027 and prior.

User Group Call Date 04/23/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	4/14/2026 12:26	RE: Questions on Part B Rx underlying the growth rate	<p>I am writing to ask for clarification on some of the supporting data that was provided in the 2027 Rate Announcement, specifically, I am trying to understand the changes to the Inpatient Trend drivers in the non-ESRD population and the ESRD Part B USPPC PMPM estimates.</p> <p>1) First, I have observed a significant decrease in the Utilization component of the Inpatient Trend from the 2027 Advance Notice to the 2027 Rate Announcement. This is captured in https://www.cms.gov/files/document/trends-supporting-2027-ratebook-growth-rates.pdf and https://www.cms.gov/files/document/trends-supporting-2027-growth-rates.pdf. For reference, the 2027 Advance Notice looks more similar to the 2026 Rate Announcement. This appears to be coinciding with an increase to the Other trend driver bucket. Can you please explain what was originally Utilization that is now classified as Other?</p> <p>2) Second, the Part B USPPC PMPMs for the ESRD population are showing a trend of 5.2% from 2025 to 2026 (\$6,241 PMPM compared to \$5,934 PMPM). This is captured in Table II-3. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPPC. Given there is a sizeable portion of Part B spend attributed to skin substitutes in 2025, I was expecting trends to be much lower going into a year without skin substitutes (closer ~2% as noted in the Advance Notice). Can you explain what is driving the 5.2% trend, which would like be >9% after normalizing for skin substitutes?</p>	<p>1) The inpatient utilization reflected in the 2026 Rate Announcement and 2027 Advance Notice exhibits include the impact of COVID-19 morbidity and demographic factors. These two items are not represented in the inpatient utilization trends in the 2027 Rate Announcement exhibit and are implicitly included in the other trend category.</p> <p>2) Skin substitutes are included in the physician-administered (PA) drug category. Changes in PA drug spending from 2025 to 2026 reduced the ESRD dialysis trend by -3.15%.</p> <p>Other categories of services with positive impact on the 2025-2026 dialysis trend are: i) dialysis services: +4.14%, (ii) outpatient hospital: +1.41%, and (iii) physician fee schedule: +1.17%.</p>
2	FFS Trends	4/17/2026 9:50	Questions on User Group Call Info, Rebate Reallocation and USPPCs	<p>On page 36 of the 2027 Rate Announcement, CMS responded to a comment about the “other” trend category for Physician services, stating “A key driver of the difference in the “other” component is the behavioral offset of +1.7% in 2025 and 0.0% in 2026.” However, in the Trends Supporting the 2027 Growth Rate document, the 2025 “other” trend category shows a -1.63%. Can OACT please clarify the assumptions or drivers contributing to the negative trend that more than offsets the +1.7% behavioral adjustment?</p>	<p>The physician fee schedule “other” trend captures impacts not explicitly included in the other trend categories, including Merit-based Incentive Payment System (MIPS) bonuses, Advanced Alternative Payment Model (APM) bonuses, legislation, and demographic changes.</p>
3	FFS Trends	4/20/2026 12:09	Questions on User Group Call Info, Rebate Reallocation and USPPCs	<p>Does the Non-ESRD USPPC include Part B inflation rebates? If so, please specify (1) which years of Part B inflation rebates are included and (2) the line item in the CY 2026 and CY 2027 Non-ESRD USPPC Reconciliation and the Key Components of United States Per Capita Cost (USPPC) Trends: 2021–2027 where these rebates are reflected?</p>	<p>The non-ESRD USPPCs supporting the 2027 Rate Announcement do not reflect any Part B inflation rebates.</p>
4	Negative Part D Premiums	4/20/2026 12:09	Questions on User Group Call Info, Rebate Reallocation and USPPCs	<p>In the release of the Final CY2027 MA BPT Instructions, Appendix E item 10.2.1 was updated to clarify guidance for RPPOs targeting LIPSA when PD Basic premium is negative at initial submission or after direct subsidy publication. Is it appropriate to apply this same guidance to non-RPPO plans in 10.1.1 which target LIPSA and have a negative PD Basic premium.</p> <p>“For plans targeting the LIPSA, [the unallocated rebate] reflects the amount necessary to return both the Part D basic premium to the LIPSA and the Part D supplemental premium to its intended level—generally resulting in a \$0 Part D premium for low-income beneficiaries...”</p>	<p>The update was intended to be for 10.1.1 and 10.2.1. Plan sponsors should apply this same guidance to both RPPO and non-RPPO plans.</p>
5	Negative Part D Premiums	4/20/2026 16:35	Questions Related to Negative Total Part D Premium Plans	<p>[Paraphrased] Would you please clarify if new plans will be subject to the OOPC comparison and if new plans will be allowed the same gain/loss margin flexibility as existing plans? What about crosswalked plans?</p>	<p>Bids new in CY2027 are subject to the same requirements as all other bids and will not be granted the gain/loss margin flexibility. Bids that have plans crosswalked into them are not considered new plans and will be evaluated the same as existing plans.</p>
6	Negative Part D Premiums	4/20/2026 16:35	Questions Related to Negative Total Part D Premium Plans	<p>Can CMS include all plan types (especially DSNP) in the TBC template so that we can validate the 2026 OOPC values for Part D?</p>	<p>This information is available to plan sponsors in HPMS.</p> <p>For MA-PDs: Quality and Performance > Performance Metrics > Reports > Costs > Part C Out-of-Pocket Costs > 2026.</p> <p>For PDPs: Quality and Performance > Performance Metrics > Reports > Costs > Part D Out-of-Pocket Costs > 2026.</p>
7	Negative Part D Premiums	4/20/2026 16:35	Questions Related to Negative Total Part D Premium Plans	<p>For plans that submit in June with a \$0 total Part D premium by utilizing a margin exception, will these plans be given the option to adjust margin to continue to target a \$0 total Part D premium during rebate reallocation? Or will margin be fixed at the June bid submission level?</p>	<p>Rebate reallocation guidance remains unchanged: plans may not adjust margins beyond Appendix E guidelines.</p>

User Group Call Date 04/23/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Negative Part D Premiums	4/20/2026 21:30	Negative Part D Premium Questions	When the NAMBA is released, if a PDP Basic plan misses the NAMBA on the high side and causes the plan to go over LIPSA in a region, will CMS allow the plan to lower margin in order to stay under the benchmark? There is significant financial risk to plan sponsors going over the LIPSA given LIPSA is potentially near \$0 and actual to expected subsidy variances could be large.	Part D bid margin will not be permitted to change. Each year CMS evaluates the de minimis amount based on availability of plans under the LI benchmarks and potential beneficiary disruption.
9	Preferred Provider Organization (PPO) Out-of-Network (OON) Coverage	N/A	N/A	Does a PPO satisfy the requirement to provide a supplemental benefit both in-network and out-of-network when coverage for the item or service is limited to a certain vendor(s), but nationally available to their enrollees?	MA PPO plans must cover all covered benefits regardless of whether those services are furnished within the plan's contracted provider network (42 C.F.R. § 422.4(a)(1)(v)). The CY 2027 Final Rule reiterates this existing requirement, including that it applies regardless of the mechanism through which a covered benefit is furnished. An out-of-network benefit that is limited to a certain vendor(s), or a catalog for a certain vendor(s), even if the benefit is nationally available to all enrollees, does not satisfy the PPO requirement of covering the benefit in-network and out-of-network. Plans should review their policies and procedures to confirm consistency with this requirement.

User Group Call Date 04/30/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/20/2026 12:09	Questions on User Group Call Info, Rebate Reallocation and USPCCs	Can OACT please provide both (1) the projected impact of the uncompensated care payment change on Part A USPCC from 2025 to 2026 and 2026 to 2027, and (2) the contribution of this change to the “other” trend category for inpatient services for 2026 and 2027, as reflected in the Trends Supporting the 2027 Growth Rate document?	The combined impact of uncompensated care payments (UCP) and disproportionate share hospital (DSH) payments is estimated to increase the non-ESRD FFS inpatient trend by 1.13% in 2026 and -0.01% in 2027. This effect is implicitly reflected in the inpatient “other” trend category.
2	Negative Part D Premium	N/A	N/A	For the CY2027 guidance that was given on last week's UGC, OACT stated that plan sponsors with a negative total Part D premium must enhance their Part D benefits to a certain level before being granted any gain/loss margin flexibility. What about basic PDPs? We are required to have a basic PDP in the region and cannot enhance benefits further and stay a basic plan.	For Basic PDP and Platino bids that are not eligible to become an Enhanced Alternative (EA) plan, the plan sponsor may increase Part D gain/loss margin to reach a \$0 total Part D premium without enhancing Part D benefits. For PDP bids, plan sponsors must ensure that the PDP aggregate gain/loss margin meets the gain/loss margin guidance. No bids may be excluded from the PDP aggregate gain/loss margin calculation.
3	Negative Part D Premium	N/A	N/A	Our parent organization utilizes Option B and is using the negative Part D total premium exception for a selection of bids. Our aggregate PD gain/loss margin is greater than our aggregate MA gain/loss margin plus 1.5%. What do we do in this situation?	For plan sponsors using Option B, the following steps are required to ensure compliance: i. Calculate the aggregate MA gain/loss margin as normal. Do not exclude any bids. ii. The Part D gain/loss margin on all other bids — excluding those bids that increased their Part D gain/loss margin to reach a \$0 total Part D premium — must be equal and within 1.5% of the aggregate MA gain/loss margin calculated in item i iii. Supporting documentation must be submitted to demonstrate compliance under this situation.
4	DSNP	04/14/2026 17:15	Reflecting D-SNP Part D Value-Add for Elimination of LI Beneficiaries' Statutory Cost Sharing in BPT	We have a follow up question regarding question #3 from the user group call on 5/29/25. Like the scenario in CMS's response, our D-SNP plan, which has a defined standard plan design, will eliminate LI beneficiaries' statutory cost sharing for Part D drugs through a Medicaid value-added service. Our question is regarding how we would report these “incurred costs” on the Part D BPT.	These Medicaid value-added benefit incurred costs are not a part of the Part D benefit and should be excluded from the BPT. In other words, the BPT should be filled out as though there were no value added services, such that the beneficiary progresses through the benefit as if they paid the cost-sharing under their Part D plan benefit.
5	Rebate Reallocation	04/23/2026 10:56	Enrollment Capacity Limit Flexibility	Will CMS consider allowing plans to update their initial June bid submission Enrollment Capacity Limit with a revised Enrollment Capacity Limit in mid-August, after the NAMBA rebate reallocation period? We believe that such flexibility would allow plans to navigate the uncertain difficulties associated with Negative Part D premiums during this bidding cycle.	Plans may not revise their requested enrollment capacity limit once it has been submitted in the initial bid. Plans should consider their unique circumstances and other contextual factors carefully when determining whether to request an enrollment capacity limit and their proposed limit. Please refer to the Final CY2027 Part C Bid Review Memorandum for additional guidance.
6	Rebate Reallocation	04/27/2026 16:22	Rebate Reallocation - Guidance Requested	[Paraphrased] What options are available to D-SNPs when SMAC-mandated benefit requirements prevent reducing benefits or increasing premiums, and Appendix E provides no alternatives for rebate reallocation in cases of NAMBA overestimation.	Please reach out to the actuarial-bids mailbox during rebate reallocation so that OACT can review your situation and work with you to identify the most appropriate solution.
7	Rebate Reallocation	04/22/2026 13:55	Question for April 30th User Group Call	[Paraphrased] Per the Q7 response from the 4/23/26 UGC, plans using a margin exception in June cannot adjust their Part D margin during rebate reallocation. If the published NAMBA results in a negative total Part D premium, can OACT clarify the expected approach for these two scenarios: 1. Basic PDP: If a Basic PDP has a negative total premium after the NAMBA release, supplemental benefit enhancement is not an option during rebate reallocation. Is additional margin flexibility permissible to achieve a non-negative total premium while maintaining Basic PDP status? 2. All Other Plans: For plans that enhanced benefits in the initial submission to the level needed (or beyond) to offset a negative total Part D premium, how should they proceed if the premium becomes negative again after the NAMBA release? Are plans expected to further enhance Part D supplemental benefits during rebate reallocation, or will additional margin flexibility be provided?	1. For Basic PDP and Platino bids that are not eligible to become an Enhanced Alternative (EA) plan, plan sponsors are permitted to increase the Part D gain/loss margin up to a \$0 total Part D premium without being required to enhance Part D benefits during rebate reallocation. 2. If your plan has already enhanced its benefits to meet or exceed the 70% DS OOPC threshold, please reach out to the actuarial-bids mailbox so that OACT can review your situation and work with you to identify the most appropriate solution.
8	Base Period Experience	04/28/2026 21:52	Worksheet 1 Base Period Experience Reporting - Sub-Capitated Paid Data with No Encounters	We would like guidance on how to report base period experience when a plan has sub-capitated a benefit, but no members utilized this benefit in the base period. Thus, there are paid amounts to report but no encounters. The only guidance in the instructions we have been able to find is “if encounter data are not available for a certain service, supporting documentation must fully explain the extenuating circumstances and remedy for the deficiency.” We do not believe this would apply in this situation as the encounter data would be available if there was utilization.	The capitation cost and the zero utilization should be reported on worksheet 1 with support explaining why there is a cost with no utilization.

User Group Call Date 05/07/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	DSNP	3/12/2026 12:12	Part D LI Copay	<p>In response to the 5/29/2025 CY2026 CMS OACT UGC Bid Question #3, OACT specified that Part D claims where LI copays are eliminated for LI members would count toward TrOOP if it</p> <ol style="list-style-type: none"> 1. Is a DSNP, 2. Uses Medicaid Value-Added Services, and 3. Is funded only by plan profits or otherwise through the sponsor’s own funds. <p>OACT also specified “TrOOP-eligibility is not dependent on whether the MCO is affiliated with an AIP, FIDE, or HIDE plan.”</p> <p>OACT referenced that these are considered “reimbursed through insurance” when the three criteria are met.</p> <p>Could OACT please clarify if these following scenarios, rather than Medicaid Value-Added Services, would also be considered “reimbursed through insurance” and therefore using these mechanisms to eliminate the Part D LI copay for LI members is permissible and the Part D claims still accumulate to TrOOP?:</p> <ol style="list-style-type: none"> 1. Using the DSNP’s MA Gain/Loss Margin (a.k.a. MA BPT WS 4, Cell H107) to cover the Part D LI Copay. 2. Using an MAO’s profits to cover the Part D LI Copay. 3. Using an organization’s investment income to cover the Part D LI Copay. 4. Using a wholly owned subsidiary (e.g. a reinsurance subsidiary or a Medicare Supplement subsidiary) to cover the Part D LI Copay. 5. Having a contractual agreement with an unrelated party (e.g. Pharmacies, PBM, etc.) to cover the Part D LI copays through their profits. 	<p>Zero-Dollar Cost Sharing Under Part D</p> <p>If an MA organization wishes to offer a D-SNP with zero-dollar cost sharing within the Part D benefit, it must buy down the entire 25% actuarial equivalent cost sharing amount using MA rebate dollars in the bid. MA organizations offering D-SNPs may not apply rebate dollars or supplemental benefits solely to the statutory nominal low-income (LI) copayment owed by certain full-subsidy beneficiaries while still receiving low-income cost-sharing subsidies (LICS) for the remainder of the cost sharing owed under the plan.</p> <p>This is because, to determine the LICS amount owed for a specific claim, section 1860D-14(c)(1)(B) of the Social Security Act (the Act) requires Part D plans, including D-SNPs, to reduce the cost sharing otherwise imposed under a plan by the amount of the applicable LICS subsidy for an LI beneficiary. Accordingly, 42 CFR 423.329(d)(1) defines the LICS payment amount as the difference between the cost sharing for a non-LI beneficiary and the nominal LI copayment. Therefore, any supplemental Part D benefit must be applied before LICS can be determined.</p> <p>Because LICS is always calculated as the difference between the cost sharing for a non-LI beneficiary (as reduced by any supplemental Part D benefit offered under the plan) and the nominal LI copayment, the nominal LI copayment cannot be eliminated unless a plan completely eliminates cost sharing for non-LI beneficiaries through the application of supplemental benefits. Accordingly, the Act prevents Part D plans, including D-SNPs, from buying down the nominal LI copayment without forfeiting LICS.</p> <p>Furthermore, the uniform benefit provision at 42 CFR 423.104(b)(2) prohibits Part D plans, including D-SNPs, from waiving the nominal LI copayment. As such, arrangements that are designed to waive the nominal LI copayment are not permissible.</p> <p>Non-Part D Wrap Coverage Options</p> <p>As CMS advised during the 2026 actuarial user group call series, non-Part D wrap coverage may, in certain circumstances, be used to provide coverage of the nominal LI copayment without requiring the plan to forfeit LICS. Specifically:</p> <ul style="list-style-type: none"> • State-only funds: States may use state-only funds to buy down the nominal LI copayment when such payments are not covered under Medicaid and are not claimed for federal Medicaid matching funds. In this scenario, an MA organization offering a D-SNP would include the nominal LI copayment amounts in the plan bid submitted to CMS and then enter into a contract with the state to provide wrap coverage that buys down the nominal LI copayment outside of the Part D benefit. Under this arrangement, any LI cost-sharing amounts paid by the state will not be treated as incurred costs for Part D drugs that and therefore do not count towards True out-of-pocket costs (TrOOP). • Medicaid value-added services: Medicaid value-added services, as defined at 42 CFR 438.3(e)(1), may also be used to buy down a beneficiary’s nominal LI copayment. To be permissible, the value-added service must be funded exclusively by plan profits or the sponsor’s own funds and must not be funded by any Medicare, Medicaid, or state-only funds. This arrangement is permissible because it reduces LI cost-sharing amounts through non-Part D wrap coverage provided outside of the Part D benefit. Under this arrangement, any LI cost-sharing amounts paid by the value-added service will be treated as incurred costs for Part D drugs that are “reimbursed through insurance.” <p>Note that these examples do not necessarily represent a complete list of permissible arrangements for reducing cost-sharing amounts for LI beneficiaries through non-Part D wrap coverage provided outside the Part D benefit.</p> <p>Important Considerations for Plan Sponsors</p> <p>To the extent that MA organizations offering D-SNPs are considering other arrangements to reduce cost-sharing amounts for LI beneficiaries through non-Part D wrap coverage provided outside of the Part D benefit, they should be aware that, if such coverage fully eliminates the nominal LI copayment and is funded by a payer that is not TrOOP-eligible (for example, state-funded wrap coverage), LI beneficiaries who would otherwise owe nominal copayments will not reach the catastrophic phase of the Part D benefit during the plan year. By contrast, if the coverage is provided by a TrOOP-eligible payer, such beneficiaries will reach the catastrophic phase.</p> <p>CMS strongly encourages MA organizations offering D-SNPs to consult with legal counsel to ensure that any arrangements under consideration to reduce LI cost-sharing amounts through non-Part D wrap coverage comply with all applicable federal laws and regulations designed to prevent fraud, waste, and abuse. This includes, but is not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §§ 3729 et seq.), and the anti-kickback provision of Section 1128B of the Act.</p>

User Group Call Date 05/07/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
2	Rebate Reallocation	5/1/2026 8:01	Question on Rebate Reallocation Language	[Paraphrased] We would like to clarify the wording in section 10.1.1 of this year's bid instructions. Specifically, could you provide additional context on what is meant by "return the Part D supplemental premium to its intended level," given that plans do not explicitly define an intended level for the supplemental premium? Our current interpretation is that, in cases where a plan has a negative Part D basic premium—either at submission or after benchmarks are released—the instructions allow plans to reallocate funds from Part C rebates to Part D supplemental benefits in order to achieve a total \$0 Part D premium. Could you confirm whether this is an accurate reflection of OACT's intent?	Our intent is to provide flexibility in situations where there is a negative Part D basic premium—either at submission or after benchmarks are released—by allowing plans to reallocate Part C rebates to the Part D supplemental premium during rebate reallocation in order to maintain a \$0 total Part D premium. For plans targeting the LIPSA, this would mean a total Part D premium equal to the LIPSA benchmark with a \$0 Part D supplemental premium. In cases where the plan has a small, non-zero total Part D premium in the initial submission, the plan may instead return, at rebate reallocation, to the original total Part D premium established at initial bid submission. Please refer to the examples provided in the February 2026 UGC.
3	Rebate Reallocation	5/1/2026 11:21	Rebate Reallocation Guidance	[Paraphrased] Regarding Guideline #11 and rebate reallocation under TBC requirements, guideline #11 permits changes to the MA gain/loss margin PMPM to meet TBC requirements, with 11.1.1 specifying that such adjustments may only occur after making changes to A/B mandatory supplemental benefits that do not affect TBC. For a plan that has already maximized TBC at the June submission, if post-NAMBA changes require rebate reallocation to maintain compliance, how should non-TBC benefits (i.e., benefits not affecting the OOPC model) be treated before adjusting the gain/loss margin PMPM? Specifically, is it correct that plans must reduce non-TBC benefits prior to adjusting gain/loss, but are not required to fully eliminate them before doing so?	If a plan has mandatory supplemental benefits that do not affect the OOPC value, the plan is expected to consider reducing those benefits prior to adjusting the gain/loss margin. However, there is no requirement that plans fully eliminate these benefits before making adjustments to the gain/loss margin. Plans must either make reasonable reductions to such benefits or provide sufficient justification for why no reductions are feasible.
4	Rebate Reallocation	5/5/2026 10:54	Formulary Change During NAMBA as Negative Premium Solve	For plans that have negative total Part D premiums during the NAMBA/rebate reallocation period and require additional Part D benefit enhancement, will CMS consider granting flexibility to update the formulary linked to the PPB during the August rebate reallocation window, given the challenges associated with solving negative Part D premiums this bid cycle? Specifically, if a sponsor submitted and received review/approval for multiple formularies by the June 1 bid deadline, could a plan that was initially linked to Formulary Y be changed to Formulary X during the August rebate reallocation window, if Formulary X was already submitted by June 1 and is linked to other plans under the same sponsor? Note that this would be a change to a richer formulary and would be a part of improving Part D benefits to eliminate negative premiums.	CMS will consider changes to a formulary crosswalk on a case-by-case basis. If approved, the changes to the formulary crosswalk must result in a decreased OOPC value.

User Group Call Date 05/14/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Negative Part D Premium	05/05/2026 18:33	Negative Premium Enhancement Clarification	<p>For CY2027 bids with negative total Part D premiums, CMS has indicated that sponsors should enhance Part D benefits until the plan reaches either a \$0 total Part D premium or the 70% defined standard Part D OOPC threshold. If the plan continues to have a negative total Part D premium after reaching the 70% threshold, our understanding is that the sponsor may increase the Part D gain/loss margin as needed to resolve the remaining negative premium.</p> <p>1) Can CMS confirm that plans will be treated consistently between initial bid submission and the August rebate reallocation period for purposes of this requirement? For example, if two plans are otherwise similarly situated and both reach the 70% defined standard Part D OOPC threshold while still having a negative total Part D premium, would CMS allow both plans to resolve the remaining negative premium through Part D margin, regardless of whether that situation is identified at initial submission or during rebate reallocation?</p> <p>2) Assuming that plans will be treated consistently, can CMS also confirm that no additional Part C benefit enhancement would be required solely because the issue is resolved during rebate reallocation rather than at initial submission?</p>	<p>This question addresses margin flexibility in the pricing review.</p> <p>1) Plan sponsors will be held to a consistent standard at initial bid submission and during the rebate reallocation period. Plan sponsors will need to enhance Part D benefits until they reach either a \$0 total Part D premium or 70% of the DS OOPC value. If the plan continues to have a negative total Part D premium after reaching the 70% threshold, the plan sponsor may then increase the Part D gain/loss margin as needed to reach the \$0 total Part D premium. For basic PDP and Platino bids that do not have the option to become EA, plan sponsors may increase Part D gain/loss margin to reach a \$0 total Part D premium without enhancing Part D benefits.</p> <p>2) We expect that the majority of negative Part D basic premium issues will be resolved during the initial submission, thereby mitigating the need for further benefit enhancements at rebate reallocation. Part C benefit enhancements to offset increased Part D margin will not be requested.</p>
2	Negative Part D Premium	05/11/2026 15:55	Question for 5/14/2026 Medicare Advantage 2027 Bid Actuarial User Group Call	<p>CMS provided guidance in the announcement for the 4/30/2026 UGC stating that if a Part D Bid's total premium is negative, the plan must enhance Part D benefits until the plan achieves either a \$0 total Part D premium or 70% of the DS OOPC value. If a Medicare Advantage Part D plan offers a defined standard plan in 2026 and intends to continue offering a defined standard plan in 2027, but its basic premium is negative, and the plan enhances Part D benefits to achieve a \$0 total Part D premium, would the plan still be required to meet the minimum 15% EA Benefit Design Value requirement outlined in Section 40 ("Definition of Enhanced Alternative Benefit Design") of the Final CY 2026 Part D Redesign Program Instructions?</p>	<p>This question addresses requirements for the benefits review.</p> <p>If the plan is a non-DSNP, plan sponsors are still required to meet the minimum 15% EA Benefit Design Value requirement. If the plan is a D-SNP, they are exempt from meeting this requirement.</p> <p>Further for the EA Benefit Design Value requirement, during the rebate reallocation period, we will exclude all Special Needs Plan types if they are required to change from a DS plan to an EA plan to add Part D supplemental benefits in order to address a negative Part D basic premium. Under these circumstances, we will simply expect that the value of their EA plan OOPC be no worse than that of the DS benefit.</p>

User Group Call Date 05/21/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Negative Part D Premium	5/5/2026 18:33	Questions for HXXXX	<p>1) Question 5 from the 4/23/26 User Group Call states that crosswalked plans are not considered new plans and will be evaluated the same as existing plans (i.e, subject to the negative premium margin flexibility rules). Does a Provider Specific Plan (PSP) qualify as a crosswalked plan since all the membership is crosswalking from an existing plan?</p> <p>2) Question 3 from the 4/30/26 User Group Call mentions using Option B to determine appropriate aggregate gain/loss margin amounts for MA and PD when some Part D plans are experiencing negative premiums. What do I do if all Part D plans have negative premiums?</p>	<p>1) If a PSP has a formal crosswalk, it is treated as an existing plan.</p> <p>2) Supporting documentation must indicate which option the parent organization is utilizing to comply with the MA vs. Part D gain/loss margin guidance. If utilizing Option B, the intended Part D margin must be included with this support. However, if all bids within the parent organization used margin flexibility to increase Part D gain/loss margin to reach a \$0 total Part D premium, the only additional requirement is that each bid's Part D OOPC be less than or equal to 70% of the bid's DS OOPC.</p>

User Group Call Date 05/28/2026

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	M3P	Live Q&A from 5/21/26 UGC	N/A	Is M3P uncollected cost share equal to bad debt written off as of 1) December 2025 or 2) actual uncollected cost share as of Dec 2025 or as of March 31 2026 or another date?	
2	Negative Part D Premium	05/23/2026 0:22	Clarification on Part D OOPC Threshold	Can OACT confirm whether the 70% DS OOPC threshold should be evaluated using a rounded percentage or the unrounded OOPC ratio? For example, if the OOPC model produces a plan Part D OOPC equal to 70.13% of the DS OOPC value, should that be treated as 70% when rounded to the nearest whole percentage, or must the unrounded ratio be at or below 70.00%?	
3	Negative Part D Premium	N/A	N/A	The updated negative part D premium guidance that OACT released in the announcements for the 4/30/26 UGC did not mention new plans. Are new plans now allowed margin flexibility if they have a negative part D total premium?	