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DATE: February 6, 2026

TO: All Prescription Drug Plans, Medicare Advantage-Prescription Drug Plans, Section 1876 Cost Plans, and PACE Organizations

FROM: Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Contract Year (CY) 2027 Final Part D Bidding Instructions

The purpose of this memorandum is to provide Part D sponsors with instructions and annual programmatic updates as they prepare to submit bids for CY 2027.

Implementation of Part D IRA Provisions

To implement applicable Part D provisions of the Inflation Reduction Act of 2022 (IRA), CMS has previously issued program instruction for CYs 2023 to 2026. CMS is in the process of codifying certain sections of this guidance which will apply beginning with 2027. Unless otherwise noted in this memorandum, please refer to the forthcoming Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program Final Rule (CY 2027 final rule).[1] For the policies on Part D coverage and cost-sharing policies for vaccines and insulin, refer to the Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (CY 2026 final rule).[2]

Annual Programmatic Updates

[1] To review the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule (90 FR 54894) which appeared in the November 28, 2025 issue of the Federal Register, please see: https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program. The comment period closed on January 26, 2026.

[2] The Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (90 FR 15792) appeared in the April 15, 2025 issue of the Federal Register. Please see: https://www.federalregister.gov/documents/2025/04/15/2025-06008/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare.

Formulary Submissions

CY 2027 Formulary Submission Windows

The CY 2027 HPMS formulary submission window will open on May 11, 2026, and close at 11:59 p.m. PDT on June 1, 2026. Consistent with 42 CFR § 423.265(b), CMS must be in receipt of a successfully submitted and validated formulary submission by the deadline of June 1, 2026 for the formulary to be considered for review. The Part D formulary is part of the plan's complete bid. Therefore, failure to submit and link a formulary to each plan that uses a formulary by the statutory deadline of the first Monday in June as required by section 1860D-11(b) of the Social Security Act (the Act) may result in denial of that bid submission (refer to section "Incomplete and Inaccurate Bid Submissions" in the CY 2020 Final Call Letter). As a reminder, Programs of All-Inclusive Care for the Elderly (PACE) organizations that intend to implement a formulary drug list or utilization management requirements for Part D drugs must also submit a formulary to CMS as outlined above.

Following the review and approval of initial CY 2027 formulary submissions, a subsequent limited update window will be provided in August 2026. We do not expect sponsors to make significant enhancements or significant negative changes to existing formulary drugs during this window, since the formulary version that was initially submitted to CMS for review was considered in the bid and Part D benefits review. Details regarding subsequent CY 2027 formulary submission windows will be provided in future HPMS memoranda.

CY 2027 Formulary Reference File (FRF)

CMS will release the first CY 2027 FRF in March 2026. The March FRF release will be used in the production of the Part D Bid Review Out-of-Pocket Cost (OOPC) model tool, scheduled to be released prior to the bid deadline. Consistent with the process for CY 2026, CMS intends to release a refreshed version of the Part D Bid Review OOPC model to account for changes in the May FRF. Given the limited timeframe between the May release of the CY 2027 FRF and the June 1, 2026 bid submission deadline, a refreshed Part D Bid Review OOPC model will be provided as quickly as possible, at least one week prior to the bid submission deadline. We note that the only change to the posted model package will be slight changes in the input files to reflect the anticipated small number of changes between the March and May FRFs. This will include FRF additions and deletions, both of which are expected to have a neutral impact or reduction in Part D OOPC estimates.

CY 2027 Prior Authorization (PA) Criteria Submission

CMS is committed to reducing provider burden and removing beneficiary access barriers associated with overly complex diagnostic criteria contained within Part D PA requirements. Diagnostic criteria are not static and, thus, frequent PA submission modifications are necessary when diagnostic information is included. Further, these complex diagnostic criteria hinder the adoption of electronic prior authorization (ePA) because of the difficulty in translating these

requirements into streamlined question sets that can be efficiently processed at the point-of-care. CMS will be scrutinizing CY 2027 PA criteria for inclusion of overly burdensome diagnostic requirements.

In an effort to reduce the burden on Part D sponsors and CMS associated with the submission and review of PA criteria, CMS has proposed changes to the HPMS PA file record layout for CY 2027.[3] These proposed changes aim to improve review efficiency, provide more standardization in the communication of criteria requirements to prescribers, beneficiaries, and other stakeholders, and promote further adoption of ePA.

Medication Therapy Management (MTM)

All Part D sponsors are required to have an MTM program designed to ensure, with respect to targeted beneficiaries, that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. MTM program requirements are codified at 42 CFR § 423.153(d). For the most recent information regarding Part D MTM programs, see the May 6, 2025 HPMS memorandum, "*Contract Year 2026 Medication Therapy Management Program Information and Submission Instructions*."

CMS proposed a change to the MTM program requirements in the 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 Proposed Rule (CY 2026 proposed rule) which appeared in the December 10, 2024 issue of the Federal Register (89 FR 99340).[4] Unless and until a final regulation establishing the proposed change to the MTM program requirements becomes effective, CMS will continue to apply policies related to the MTM program requirements at 42 CFR § 423.153(d) in the same manner as they were applied for CY 2026.

A CY 2027 MTM memorandum will be released in April or May 2026. The memorandum will be available on the CMS.gov MTM page at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.

CY 2027 MTM Submissions and Attestations

Annually, sponsors submit an MTM program description to CMS through HPMS for review and

[3] CMS released an information collection request (ICR) titled "CMS Plan Benefit Package (PBP) and Formulary CY 2026 (CMS-R-262)" on December 22, 2025. The ICR can be found in the Federal Register at https://www.federalregister.gov/documents/2025/12/22/2025-23582/agency-information-collection-activities-proposed-collection-comment-request. The full text of the ICR can also be found at CMS' PRA website at: https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing. Comments are due by February 20, 2026.

[4] See https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare.

approval. CMS evaluates each program description to verify that it meets the current minimum requirements for the program year. These requirements do not apply to MA Private Fee for Service (MA-PFFS) organizations (see 42 CFR § 423.153(e)) or PACE organizations. The requirements do apply to Employer Group Waiver Plans (EGWPs).

The CY 2027 HPMS MTM program submission window will open on May 20, 2026 and close at 11:59 p.m. PDT on June 3, 2026. The attestation link will be available on June 4, 2026. The CY 2027 MTM program attestation deadline is June 17, 2026 at 11:59 p.m. PDT.

Annual Cost Threshold

Beginning January 1, 2025, per 42 CFR § 423.153(d)(2)(i)(C), the MTM cost threshold is set at the average annual cost of eight generic drugs, as defined at 42 CFR § 423.4, and determined using the prescription drug event (PDE) data specified at 42 CFR § 423.104(d)(2)(iv)(C). The 2026 MTM cost threshold is $1,276. Based on analysis of 2025 PDE data, the MTM cost threshold will be $1,340 for 2027.

Part D Benefit Parameters for Non-Defined Standard Plans

Part D sponsors can offer Non-Defined Standard Plans under which they can modify certain benefit parameters, including tiered cost sharing. The CY 2027 Part D benefit parameters for Non-Defined Standard Plans are set forth in the table below, addressing four key areas: 1) Enhanced Alternative (EA) value, 2) standalone Prescription Drug Plan (PDP) meaningful difference, 3) tiered cost sharing thresholds, and 4) the specialty tier threshold.

1. Pursuant to 42 CFR § 423.104(f), EA coverage must include both required basic prescription coverage and supplemental benefits.

2. Pursuant to 42 CFR § 423.272(b)(3)(i), CMS will only approve a bid submitted by a Part D sponsor if its PBP or plan cost structure is substantially different from those of other plan offerings by the sponsor in the service area, with respect to key characteristics such as beneficiary out-of-pocket costs and formulary structures.

3. Pursuant to 42 CFR § 423.104(d)(2)(iii), tiered cost sharing for non-defined standard benefit designs may not exceed levels annually determined by CMS to be discriminatory.

4. Pursuant to 42 CFR § 423.104(d)(2)(iv), CMS annually reviews and establishes a dollar-per-month threshold for specialty tier eligibility. CMS will use the values included in the chart below as part of our benefit and formulary review and negotiation of CY 2027 bids.

CMS will scrutinize plan benefits that do not meet these parameters pursuant to our negotiation authority under 42 CFR § 423.272(a).

EA Benefit Design Value

For CY 2027, CMS is maintaining the EA benefit value requirements outlined in the Final CY 2026 Part D Redesign Program Instructions, released on April 7, 2025.[5] Please refer to section 40. Definition of Enhanced Alternative Benefit Design (§ 423.104(f)), beginning on page 29, for more details.

PDP Meaningful Difference

For CY 2027, CMS is maintaining the meaningful difference requirements outlined in the Final CY 2026 Part D Redesign Program Instructions, released on April 7, 2025 (see footnote 5). Please refer to Section 50. PDP Meaningful Difference (42 CFR § 423.265(b)(2)), beginning on page 33, for more details. Note that this continues to be a two-pronged requirement, where the enhanced plan must meet the requirements for the proportion of the enhancement attributable to benefit design and tier placement versus formulary robustness, in addition to having an OOPC estimate at least 10 percent better (i.e., lower) than the corresponding basic plan.

Tiered Cost-Sharing Thresholds

The Non-Defined Standard cost-sharing thresholds remain unchanged for CY 2027, as detailed below in the Benefit Parameters for CY 2027 Threshold Values chart. CMS reminds sponsors that they must adhere to these thresholds even if submitting a "defined standard like" plan where they use a tiered benefit design but assign 25 percent coinsurance to each tier. This 25 percent cost sharing is not allowable for Select Care, Select Diabetic or Vaccine tiers, where the coinsurance thresholds are no greater than 15 percent for Select Drug tiers and $0 for Vaccine tiers because CMS will not approve a coinsurance amount that exceeds our tier level thresholds. As such, sponsors should either select a different tier model that does not include Select Drug or Vaccine tiers or reduce the coinsurance amount to align with the tier thresholds.

Specialty Tiers

Part D sponsors may exempt formulary tiers in which they place very high-cost Part D drugs from their tiering exceptions process, consistent with 42 CFR § 423.578(a)(6)(iii). As codified in 42 CFR § 423.104(d)(2)(iv), in order for a Part D sponsor to place a Part D drug on a specialty tier, a Part D drug's 30-day equivalent ingredient cost must exceed a dollar-per-month threshold annually reviewed and established by CMS. Consistent with the methodology at 42 CFR § 423.104(d)(2)(iv)(B)(1), the specialty-tier threshold is increased for a plan year only if the dollar amount that equals the lowest 30-day equivalent ingredient cost that is within the top 1 percent of all 30-day equivalent ingredient costs reflected in PDE data is at least 10 percent above the specialty tier threshold for the current plan year. The last time this threshold was increased was for CY 2024. While analyses for CY 2025 and CY 2026 revealed that the lowest 30-day equivalent ingredient cost that is within top 1 percent of all 30-day equivalent ingredient costs

[5] Please see: https://www.cms.gov/files/document/final-cy-2026-part-d-redesign-program-instruction.pdf.

exceeded $950, the increase did not meet the 10 percent threshold to make an adjustment.

For CY 2027, the specialty-tier cost threshold analysis results in a threshold of $1,080, which is a 13.7 percent increase from the current $950 threshold. Since this exceeds 10 percent, the CY 2027 specialty-tier cost threshold will increase to $1,080 for a 30-day equivalent ingredient cost.

Consistent with 42 CFR § 423.104(d)(2)(iv)(D), CMS sets the maximum allowable cost sharing for a single specialty tier, or, in the case of a plan with two specialty tiers, the higher cost-sharing specialty tier, at 25 percent if the plan requires the standard deductible, 33 percent cost sharing if no deductible is required, or some percentage in between dependent on a decreased deductible. Effective January 1, 2025, the initial coverage limit (ICL), which moved a beneficiary from the initial coverage phase into the coverage gap phase, was eliminated by the IRA, rendering the methodology codified at 42 CFR § 423.104(d)(2)(iv)(D)(3) invalid. CMS, therefore, established a new methodology to calculate maximum allowable specialty tier cost sharing in the Final CY 2025 Part D Redesign Program Instructions. In the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule (the CY 2027 proposed rule) we proposed to maintain this methodology for CY 2027.[6] Please refer to the forthcoming CY 2027 final rule for the final codified policy.

Annually, CMS updates the statutory parameters for the defined standard Part D drug benefit. Following publication of the CY 2027 Rate Announcement, CMS will release the specialty tier deductible ranges corresponding to each coinsurance percentage in HPMS, via the following path: Plan Bids → Plan Benefit Package → Documentation → PBP CY 2027 Annual Updates for Specialty Tier Calculations.

For plans that offer two specialty tiers, the cost sharing for the preferred specialty tier must be anything less than that of the higher cost-sharing specialty tier.

Benefit Parameters for CY 2027 Threshold Values

	CY 2027 Threshold Values
Minimum Value of an EA plan (EA plan OOPC)	
Enhanced Alternative Plan vs. Defined Standard Plan	15%
Minimum Meaningful Differences (PDP Cost-Sharing OOPC)	
Enhanced Alternative Plan vs. Basic Plan	10%
Proportion of Meaningful Difference attributed to formulary robustness	≥0%

[6] Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule (90 FR 54894) appeared in the November 28, 2025 issue of the Federal Register. The comment period closed on January 26, 2026, please see: https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program.

	CY 2027 Threshold Values
Proportion of Meaningful Difference attributed to benefit design and tier placement	>50%
Maximum Copay: Initial Coverage Phase (3 or more tiers)	S[1,2]
Preferred Generic Tier	<$20[3]
Generic Tier	$20
Preferred Brand/Brand Tier	$47
Non-Preferred Drug Tier	$100
Non-Preferred Brand Tier	$100
Injectable Tier	$100
Select Care/Diabetic Tiers[4]	$11
Vaccine Tier	$0
Maximum Coinsurance: Initial Coverage Phase (3 or more tiers)	S[1,2]
Preferred Generic Tier	25%
Generic Tier	25%
Preferred Brand/Brand Tier	25%
Non-Preferred Drug Tier	50%
Non-Preferred Brand Tier	50%
Injectable Tier	33%
Select Care/Diabetic Tiers[4]	15%
Vaccine Tier	0%
Minimum Specialty Tier Eligibility	
30-day equivalent ingredient cost	$1,080

[1] These thresholds are based on the 95th percentile of the CY 2026 Bid Data, which are unchanged from the thresholds based on the 95th percentile of the CY 2020 Bid Data. We will separately evaluate plans with atypical tiering structures, such as a two-tier formulary.
[2] "S" in the above chart refers to "standard retail cost sharing" at a network pharmacy. Standard retail cost sharing (S) is cost sharing other than preferred retail cost sharing offered at a network pharmacy.
[3] There is no separate maximum cost-share threshold for the Preferred Generic tier. Cost sharing for the Preferred Generic tier lower than that of the cost sharing for the Generic tier will not be subject to additional scrutiny. Equivalent cost sharing for the Preferred Generic and Generic tiers will be accepted only in cases where the sponsor buys down the cost sharing to $0 for both generic tiers.
[4] The Select Care Drug and Select Diabetic Drug tiers provide a meaningful benefit offering when they have low or $0 beneficiary cost sharing for drugs targeting specific conditions (e.g., $0 tier for drugs related to diabetes and/or smoking cessation).

Tier Composition

As stated in the Final CY 2020 Call Letter, CMS expects drug tier labels to be representative of the drugs that make up those tiers. For CY 2027, we intend to maintain the maximum threshold of 25

percent generic composition for the Non-Preferred Brand tier, as outlined in the Final CY 2020 Call Letter. CMS has continued to evaluate the other tiers, such as the Preferred Brand tier, to ensure that the drug tier label is representative of the drugs that make up that tier, because the inclusion of a significant number of generic drugs on a tier that is labeled as brand is misleading and may lead to beneficiary confusion. In the CY 2026 proposed rule,[7] CMS reiterated our commitment to ensuring robust access to generics and biosimilars and sought comment on whether CMS should take programmatic action to prevent Part D formularies from disfavoring coverage of generics, biosimilars, and other low-cost drugs. While we did not ultimately finalize changes to our extensive formulary review process, we maintain our commitment to ensuring Part D sponsors provide an adequate formulary consistent with 42 CFR § 423.120(b)(2). In our evaluation of Part D sponsors' tier composition over time, CMS has noted a growing number of generic drugs placed on the Preferred Brand tier.

CMS reminds sponsors that there are several tier models that include both a Preferred Generic and Generic tier, which can be used to differentiate between generic drugs on their formularies. We are seeing more plans place their nonpreferred generic drugs on the Preferred Brand tier with a coinsurance cost-share structure. Both the Generic and Preferred Brand tiers have a coinsurance threshold of 25 percent, meaning that use of either tier offers the necessary flexibility to effectively encourage generic utilization without creating confusion due to the inclusion of generics on tiers with tier labels that are inconsistent with the tier composition. In other words, instead of charging a very low copay on both the preferred generic tier and generic tier, a coinsurance could be used on the generic tier to achieve a similar benefit design without the need to place a large proportion of generic drugs on a brand-labeled tier. CMS will continue to evaluate the brand and generic composition of formulary tiers as part of the bid review process. For CY 2027, we intend to maintain the maximum threshold of 25 percent generic composition for the Non-Preferred Brand tier, as outlined in the Final CY 2020 Call Letter. While we are not establishing a generic composition threshold for the Preferred Brand tier for CY 2027, CMS will continue to evaluate the other tiers on each sponsor's formulary, including the Preferred Brand tier, to ensure that the drug tier label is representative of the drugs that make up that tier.

Improving Drug Utilization Review Controls in Medicare Part D

Opioid Safety Edits

For the most recent information regarding Part D opioid point-of-sale (POS) safety edit(s), see the July 3, 2025, HPMS memorandum, "*Contract Year (CY) 2026 Medicare Part D Opioid Safety Edits – Submission Instructions, Recommendations, and Reminders*." Guidance for sponsors and educational materials for providers and beneficiaries are available on the Improving Drug Utilization Review Controls in Part D webpage: https://www.cms.gov/Medicare/Prescription- Drug- Coverage/PrescriptionDrugCovContra/RxUtilization.html. CMS will continue to update this

[7] See https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare.

page, including the FAQs, to provide additional guidance as needed for CY 2027 and future years.

A memorandum providing instructions to Part D sponsors for submitting information about CY 2027 opioid POS safety edits to CMS in HPMS will be released in July 2026. Sponsors should submit opioid safety edits in HPMS module between August 12, 2026 and 5:00 p.m. EDT on August 19, 2026. For CY 2027, CMS requests that all PACE organizations submit opioid safety edit information in HPMS regardless of whether or not they adjudicate claims at POS.

Drug Management Programs (DMPs)

All Part D sponsors are required to have a DMP. DMP requirements are codified at 42 CFR § 423.153(f). See the December 16, 2025 HPMS memorandum, "*UPDATE: Contract Year 2026 Part D Drug Management Program Guidance*," for the most recent information regarding Part D DMPs.

Guidance, technical documents, notices, and FAQs for DMPs are available on the Improving Drug Utilization Review Controls in Part D webpage: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html. CMS will continue to update this page to provide additional guidance as needed for CY 2027 and future years.

Coordination of Benefits (COB) User Fee

Pursuant to section 1860D-24(a)(3) of the Act and 42 CFR § 423.464(c), CMS is authorized to impose user fees on Part D sponsors for the transmittal of information necessary for benefit coordination between sponsors and other entities providing prescription drug coverage. We review and update this user fee annually to reflect the costs associated with COB activities for the specific year. The 2027 COB user fee will be collected at a monthly rate of $0.067 for the first 9 months of the coverage year, for a total user fee of $0.60 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2027 bids.

Administrative Information

The programmatic policies described in this memorandum will be used in the evaluation of CY 2027 bids submitted by Part D sponsors in accordance with our negotiation authority under section 1860D-11(d)(2) of the Act. Unless otherwise noted in this document, the guidance issued in the Final CY 2020 Call Letter still applies for CY 2027 (see CY 2020 Final Call Letter). The following is a non-exhaustive list of CY 2020 Call Letter policies that apply for CY 2027:

- Incomplete and Inaccurate Bid Submissions
- Plan Corrections
- Improving Access to Opioid-Reversal Agents
- Access to Medication-Assisted Treatment
- Improving Access to Generic and Biosimilar Medicines*

- Low Enrollment Plans (Standalone PDPs only)
- Part D Mail Order Auto-Ship Modifications

* See also the discussion with policy reminders and clarifications in the CY 2026 proposed rule (89 FR 99471). As noted in the CY 2026 final rule, these policy reminders and clarifications continue to apply (90 FR 15795).

For questions related to Part D Benefits, email PartDBenefits@cms.hhs.gov.
For questions related to Part D Policy, email PartDPolicy@cms.hhs.gov.
For questions related to Part D Formularies, email PartDFormularies@cms.hhs.gov.
For questions related to Part D MTM Programs, email PartD_MTM@cms.hhs.gov.
For questions related to Part D opioid safety edits or DMPs, email PartD_OM@cms.hhs.gov.
For questions related to the Part D Bid Pricing Tools, email actuarial-bids@cms.hhs.gov.
For questions related to Part D Payment Policy, email PartDPaymentPolicy@cms.hhs.gov.