

DEPARTMENT OF HEALTH & HUMAN SERVICES  
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**DATE:** April 1, 2025

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

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

**SUBJECT:** Contract Year (CY) 2026 Final Part D Bidding Instructions

The purpose of this memorandum is to provide Part D sponsors with instructions as they prepare to submit bids for CY 2026. This memorandum includes annual programmatic updates and serves to supplement the forthcoming Final CY 2026 Part D Redesign Program Instructions document<sup>1</sup> which will include program instructions for 2026 for the implementation of provisions enacted in the Inflation Reduction Act (IRA, P.L. [117-169](#)), on August 16, 2022.

### **Implementation of Part D IRA Provisions**

In order to implement applicable Part D provisions of the IRA, CMS has previously issued program instruction via the Health Plan Management System (HPMS) for both CY 2023 and CY 2024. Except for the forthcoming Final CY 2026 Part D Redesign Program Instructions, the previous instructions still apply:

- [Final Contract Year \(CY\) 2024 Part D Bidding Instructions](#)
- [Final CY 2025 Part D Redesign Program Instructions](#)

For the policies on Part D coverage and cost-sharing policies for vaccines and insulin, refer to the forthcoming 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.<sup>2</sup>

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<sup>1</sup> CMS released the Draft CY 2026 Part D Redesign Program Instructions on January 10, 2025 and voluntarily solicited comment on these draft program instructions. The comment period closed on February 10, 2025. Please see <https://www.cms.gov/files/document/draft-cy-2026-part-d-redesign-program-instructions.pdf>.

<sup>2</sup>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 (89 FR 99340) appeared in the December 10, 2024 issue of the Federal Register. The comment period closed on January 27, 2025. Please 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>.

## Annual Programmatic Updates

### **Prescription Drug Plan Crosswalk Policy**

CMS reminds organizations that the changes to the crosswalk policy for individual-market stand-alone Prescription Drug Plans (PDPs) finalized in the rule that appeared in the April 23, 2024 issue of the Federal Register will be effective for the first time during the CY 2026 bid cycle. The PDP crosswalk requirements are codified at 42 CFR § 423.530. As in previous years, CMS will not approve any crosswalk that will split the enrollment in one PDP plan benefit package (PBP) between two or more PDP PBPs, nor will CMS approve any crosswalk from a PDP PBP offering basic prescription coverage to a PDP PBP offering enhanced prescription drug coverage (42 CFR § 423.530(a)(2)(ii) & (iii)).

Organizations that plan to continue operating a CY 2025 PDP PBP offering basic or enhanced coverage in CY 2026 must submit a crosswalk request through HPMS by the CY 2026 bid deadline of June 2, 2025. The PBP number for 2026 must remain the same as the PBP number for 2025 and the service area associated with the PBP must also remain the same. Organizations cannot discontinue a 2025 PDP PBP offering basic coverage in a service area without non-renewing all individual market PDP PBPs (basic and enhanced) under that contract in that service area for 2026. Organizations cannot discontinue a 2025 PDP PBP offering enhanced coverage in a service area and create a new PDP PBP offering enhanced coverage in that service area under the same contract for 2026.

Any other crosswalks must be requested through the crosswalk exception process in HPMS. For CY 2026, consolidated renewals for individual-market PDPs can no longer be submitted through the regular crosswalk module in HPMS.

As an example, consider a sponsor that offers basic plan 001 and enhanced plan 002 in 2025 and intends to consolidate these two plans into basic plan 001. In the regular crosswalk module, prior to the bid deadline, the sponsor should indicate that plan 001 will renew and plan 002 will terminate. During the first round of crosswalk exception submissions, the sponsor should submit a request for the consolidated renewal of plan 002 into plan 001. The initial deadline for submitting crosswalk exception requests is June 4, 2025. The review of crosswalk exceptions takes place after the bid deadline and as such, if CMS denies a crosswalk exception request, there is **no** opportunity for an organization to reconsider and submit a bid for the plan that was initially terminated.

There are two types of crosswalks that CMS may approve through the exceptions process if the requirements of 42 CFR § 423.530(c) are met:

- **Consolidated Renewals:** Organizations may discontinue a 2025 PDP PBP offering enhanced alternative coverage and crosswalk enrollment into a 2025 PDP PBP offered under the same contract that they plan to continue operating in 2026. Organizations should indicate in the bid submission module via the plan crosswalk they submit on or before June 2, 2025 that the 2025 PDP PBP is terminated. CMS may approve a request for a consolidated renewal crosswalk exception **only** if all the requirements in 42 CFR § 423.530(c)(1) are met, including:
  - The receiving PBP ID must be the same as one of the PBP IDs offered in 2025;

- The PBPs being consolidated must be under the same PDP contract;
  - A PBP offering basic prescription drug coverage may not be discontinued if the PDP contract continues to offer coverage, other than employer group waiver plans, in the service area of the PBP;
  - Enrollment from a PBP offering enhanced alternative coverage may be crosswalked into a PBP offering enhanced alternative or basic prescription drug coverage;
  - If the PDP contract includes more than one renewing PBP into which enrollment of the discontinuing PBP can be crosswalked, enrollment must be crosswalked into the PBP that will result in the lowest increase in monthly premiums for enrollees (as reflected the bid submitted for the surviving contract on or before June 2, 2025); and
  - The crosswalk does not result in a 2026 premium increase for beneficiaries exiting the discontinued PBP (as reflected in the bid for the receiving PBP submitted on or before June 2, 2025) that exceeds the greater of either the 2025 premium for the non-renewing PBP or the 2025 average base beneficiary premium for the PDP region in which the PBP operates. In other words, if the 2025 premium is greater than the 2025 applicable average base beneficiary premium, then the 2026 premium may not exceed an amount twice the 2025 premium. If the 2025 premium is less than the 2025 applicable average base beneficiary premium, then the 2026 premium may not exceed an amount twice the 2025 applicable average base beneficiary premium.
- **Contract Consolidations:** Organizations may non-renew all or part of the service area of a PDP contract and crosswalk enrollment from the nonrenewing PBPs into another PDP contract (known as the “surviving contract”) for 2026. A memorandum notifying Part D sponsors of the availability of the Service Area Reduction (SAR) Module in HPMS will be released in April 2025. Organizations should follow the instructions in this non-renewal and service area reduction guidance to indicate that they intend to non-renew or reduce the service area of the 2025 PDP they intend to consolidate with another PDP contract in 2026. CMS may approve a contract consolidation crosswalk exception request only if all the requirements in 42 CFR § 423.530(c)(2) are met, including:
    - The PDP contract that is discontinuing coverage and the surviving PDP contract are held by the same legal entity or by legal entities with the same parent organization;
    - The approved 2026 service area for the surviving contract includes the service area of the discontinuing PBPs whose enrollment will be crosswalked;
    - Enrollment may be crosswalked from a PBP offering basic prescription drug coverage into a PBP offering basic prescription drug coverage;
    - Enrollment may be crosswalked from a PBP offering enhanced alternative coverage into a PBP offering either enhanced alternative or basic prescription drug coverage;
    - Enrollment from a PBP offering enhanced alternative coverage must be crosswalked into the PBP in the surviving contract that will result in the lowest premium increase

(as reflected the bid submitted for the surviving contract on or before June 2, 2025); and

- The crosswalk does not result in a 2026 premium increase for beneficiaries exiting the discontinued PBP (as reflected in the bid for the receiving PBP submitted on or before June 2, 2025) that exceeds the greater of either the 2025 premium for the non-renewing PBP or the 2025 average base beneficiary premium for the PDP region in which the PBP operates. In other words, if the 2025 premium is greater than the 2025 applicable average base beneficiary premium, then the 2026 premium may not exceed an amount twice the 2025 premium. If the 2025 premium is less than the 2025 applicable average base beneficiary premium, then the 2026 premium may not exceed an amount twice the 2025 applicable average base beneficiary premium.

Organizations discontinuing a 2025 PDP PBP offering enhanced alternative coverage that do not request and receive approval for a crosswalk exception for a consolidated renewal of the discontinuing PBP may not be approved to operate a new enhanced alternative PDP PBP in the same service area as the non-renewing PBP in 2026 (42 CFR § 423.530(c)(1)(vii)).

Organizations should note that nothing in the PDP crosswalk process permits the crosswalk of enrollees in an employer group health or waiver plan PBP to another PBP outside the usual process for enrollment in employer group health or waiver plans (42 CFR § 423.530(a)(5)).

Organizations with questions about the new PDP crosswalk process and requirements should contact [PartDBenefits@cms.hhs.gov](mailto:PartDBenefits@cms.hhs.gov).

## **Formulary Submissions**

### ***CY 2026 Formulary Submission Windows***

The CY 2026 HPMS formulary submission window will open on May 9, 2025 and close at 11:59 p.m. PDT on June 2, 2025. 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 2, 2025 in order 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 2026 formulary submissions, a subsequent limited update window will be provided in August 2025. 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 2026 formulary submission windows will be provided in future HPMS memoranda.

## ***CY 2026 Formulary Reference File (FRF)***

CMS will release the first CY 2026 FRF in March 2025. 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 2025, 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 2026 FRF and the June 2, 2025 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 both FRF additions and deletions, both of which are expected to have a neutral impact or reduction in Part D OOPC estimates.

## **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, 2024 HPMS memorandum, “*Contract Year 2025 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 which appeared in the December 10, 2024 issue of the Federal Register (89 FR 99340). Until such time as a final regulation addressing the proposal 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 2025.

A CY 2026 MTM memorandum will be released in April or May 2025. The memorandum will be available on the CMS.gov MTM page at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM>.

## ***CY 2026 MTM Submissions and Attestations***

Annually, sponsors submit an MTM program description to CMS through the HPMS for review and 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 2026 HPMS MTM program submission window will open on May 21, 2025 and close at 11:59 p.m. PDT on June 4, 2025. The attestation link will be available on June 5, 2025. The CY 2026 MTM program attestation deadline is June 18, 2025 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 2025 MTM cost threshold is \$1,623. Based on analysis of 2024 PDE data, the MTM cost threshold will be \$1,276 for 2026.

## **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 2026 Part D benefit parameters for Non-Defined Standard Plans are set forth in the table below, addressing three key areas: Standalone Prescription Drug Plan (PDP) meaningful difference, tiered cost sharing, and the specialty tier threshold. 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. 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. CMS will use the values included in the chart below as part of our benefit and formulary review and negotiation of CY 2026 bids. CMS will scrutinize plan benefits that do not meet these parameters pursuant to our negotiation authority under 42 CFR § 423.272(a).

### ***PDP Meaningful Difference***

Refer to the forthcoming Final CY 2026 Part D Redesign Program Instructions document for meaningful difference requirements for CY 2026.

CMS released the Draft CY 2026 Part D Redesign Program Instructions on January 27, 2025<sup>3</sup> and voluntarily sought comment on these draft program instructions. CMS will issue the final program instructions for 2026 after considering the public comments received in response to the draft program instructions. In the final program instructions, CMS may change any policies, including policies on which CMS has not expressly solicited comment, based on the agency's further consideration of the relevant issues. Policies established in the final program instructions for 2026 are subject to change in subsequent years.

### ***Cost-Sharing Thresholds***

The Non-Defined Standard cost-sharing thresholds remain unchanged for CY 2026, as detailed below in the Benefit Parameters for CY 2026 Threshold Values chart.

### ***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

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<sup>3</sup> The Draft CY 2026 Part D Redesign Program Instructions are available at <https://www.cms.gov/files/document/draft-cy-2026-part-d-redesign-program-instructions.pdf>.

annually reviewed and established by CMS. For CY 2026, the specialty-tier cost threshold will remain the same as for CY 2025, at \$950 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. This methodology contains references to the CY 2025 Part D benefit parameters as described in the CY 2025 Advance Notice and CY 2025 Rate Announcement.

Annually, CMS updates the statutory parameters for the defined standard Part D drug benefit. As such, the specific CY 2025 benefit parameters referenced in the Final CY 2025 Part D Redesign Program Instructions do not apply for CY 2026. The methodology to calculate the maximum allowable cost sharing for the specialty tier, as described in the Final CY 2025 Part D Redesign Program Instructions, will still apply for CY 2026; however, the benefit parameters will be updated to reflect those specified in the CY 2026 Rate Announcement. Following publication of the CY 2026 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 CY2026 Annual Updates for Specialty Tier Calculations.

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

#### Benefit Parameters for CY 2026 Threshold Values

	CY 2026 Threshold Values
Minimum Meaningful Differences (PDP Cost-Sharing OOPC)	
Enhanced Alternative Plan vs. Basic Plan	Refer to CY 2026 Part D Redesign Program Instructions
Maximum Copay: Initial Coverage Phase (3 or more tiers)	\$ <sup>1,2</sup>
Preferred Generic Tier	<\$20 <sup>3</sup>
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 <sup>4</sup>	\$11
Vaccine Tier	\$0
Maximum Coinsurance: Initial Coverage Phase (3 or more tiers)	\$ <sup>1,2</sup>



	CY 2026 Threshold Values
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 <sup>4</sup>	15%
Vaccine Tier	0%
Minimum Specialty Tier Eligibility	
30-day equivalent ingredient cost	\$950

<sup>1</sup> These thresholds are based on the 95<sup>th</sup> percentile of the CY 2025 Bid Data, which are unchanged from the thresholds based on the 95<sup>th</sup> percentile of the CY 2020 Bid Data. We will separately evaluate plans with atypical tiering structures, such as a two-tier formulary.

<sup>2</sup> “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.

<sup>3</sup> There is no separate maximum cost-share threshold for the Preferred Generic tier. Cost sharing for the Preferred Generic tier that is lower than 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.

<sup>4</sup> 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).

## 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 5, 2024 HPMS memorandum, “Contract Year (CY) 2025 *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 page, including the FAQs, to provide additional guidance as needed for CY 2026 and future years.

A memorandum providing instructions to Part D sponsors for submitting information about CY 2026 opioid POS safety edits to CMS in HPMS will be released in July 2025. Sponsors should submit opioid safety edits in the HPMS module between August 13, 2025 and 5:00 p.m. EDT on August 20, 2025. For CY 2026, 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 November 18, 2024 HPMS memorandum, “*Contract Year 2025 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 2026 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 2026 COB user fee will be collected at a monthly rate of \$0.072 for the first 9 months of the coverage year, for a total user fee of \$0.65 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2026 bids.

### **Administrative Information**

The programmatic policies described in this memorandum will be used in the evaluation of CY 2026 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 or the forthcoming Final CY 2026 Part D Redesign Program Instructions document, the guidance issued in the Final CY 2020 Call Letter still applies for CY 2026 (see [CY 2020 Final Call Letter](#)). The following is a non-exhaustive list of CY 2020 Call Letter policies that apply for CY 2026:

- Incomplete and Inaccurate Bid Submissions
- Plan Corrections
- Improving Access to Opioid-Reversal Agents
- Access to Medication-Assisted Treatment
- Tier Composition
- Improving Access to Generic and Biosimilar Medicines\*
- Low Enrollment Plans (Standalone PDPs only)
- Part D Mail Order Auto-Ship Modifications\*\*

\* Denotes a policy included in the CY 2026 proposed rule, which appeared in the December 10, 2024 issue of the Federal Register. Until such time as a final regulation addressing this proposal becomes effective, CMS will continue to apply the policy in the same manner as it was applied for CY 2025.

\*\* Denotes a policy included in the CY 2024 proposed rule, which appeared in the December 27, 2022 issue of the Federal Register. Until such time as a final regulation addressing this proposal becomes effective, CMS will continue to apply the policy in the same manner as it was applied for CY 2025.

For questions related to Part D Benefits, email [PartDBenefits@cms.hhs.gov](mailto:PartDBenefits@cms.hhs.gov).

For questions related to Part D Policy, email [PartDPolicy@cms.hhs.gov](mailto:PartDPolicy@cms.hhs.gov).

For questions related to Part D Formularies, email [PartDFormularies@cms.hhs.gov](mailto:PartDFormularies@cms.hhs.gov).

For questions related to Part D MTM Programs, email [PartD\\_MTM@cms.hhs.gov](mailto:PartD_MTM@cms.hhs.gov).

For questions related to Part D opioid safety edits or DMPs, email [PartD\\_OM@cms.hhs.gov](mailto:PartD_OM@cms.hhs.gov).

For questions related to the Part D Bid Pricing Tools, email [actuarial-bids@cms.hhs.gov](mailto:actuarial-bids@cms.hhs.gov).  
For questions related to Part D Payment Policy, email [PartDPaymentPolicy@cms.hhs.gov](mailto:PartDPaymentPolicy@cms.hhs.gov).