DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 422

[CMS-4208-F2]

RIN 0938-AV40

Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE)--Finalization of Format Provider Directories for Medicare Plan Finder

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule implements Medicare Advantage disclosure requirement changes.

DATES: *Effective date*: These regulations are effective November 17, 2025.

Applicability date: This final rule is applicable beginning January 1, 2026.

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SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

The primary purpose of this final rule is to amend the regulations pertaining to disclosure requirements under 42 CFR 422.111 for the Medicare Advantage (MA) (that is, Part C) program. In this final rule, CMS is finalizing a new requirement that will increase beneficiaries' access to provider data while comparing plans in the CMS Medicare Plan Finder (MPF) tool, which will contribute to the beneficiaries' ability to make more informed decisions about their health care.

B. Summary of the Provision– Format Provider Directories for Medicare Plan Finder

CMS is finalizing the proposed requirement for MA provider directory data to be submitted to CMS/HHS for publication online in accordance with guidance from CMS/HHS. In addition, CMS is finalizing the proposal that MA provider directory data be updated within 30 days of the date an MA organization becomes aware of changes to that data. CMS is also finalizing the proposal to require MA organizations to attest at least annually that the MA provider directory information is accurate when the attestation is provided to CMS. These regulatory changes will further promote informed beneficiary choice and transparency found in online resources, empowering people with Medicare to make informed choices about their coverage. CMS is not finalizing the portion of the proposal that would have required MA organizations to attest that their MA provider directory data are consistent with data submitted to comply with CMS's MA network adequacy requirements under § 422.116(a)(2)(i). MA organizations already attest that they have an adequate network for access and availability of a specific provider or facility type.

C. Summary of Costs and Benefits

TABLE 1: SUMMARY OF COSTS AND BENEFITS

Provision	Description	Financial Impact
Format Provider Directories for Medicare Plan Finder	To require MA provider directory data, as required under § 422.111(b)(3)(i), to be submitted to CMS/HHS for publication online in a format, manner, and timeframe determined by CMS/HHS. Additionally, to also require MA organizations to attest at least annually that this information is accurate when the attestation is submitted to CMS in accordance with guidance from CMS/HHS. CMS is not finalizing the portion of the proposed attestation requirement that would have required MA organizations to attest that the provider directory data are consistent with data submitted to comply with CMS's MA network adequacy requirements at § 422.116(a)(2)(i). MA organizations already attest that they have an adequate network for access and availability of a specific provider or facility type.	These changes will not affect the Medicare Trust fund. The paperwork burden is $500,000 annually.

D. Publication of the Proposed and Final Rules

The proposed rule titled "Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" appeared in the December 10, 2024, **Federal Register** (89 FR 99340) (hereinafter referred to as the "December 2024 proposed rule").

In response to the December 2024 proposed rule, CMS received approximately 31,227 timely pieces of correspondence containing multiple comments on the proposed rule, with approximately 130 received about the provision to format provider directories for MPF being finalized here. CMS notes that some of the public comments were outside of the scope of the proposed rule.

In the subsequent final rule of the same title that appeared in the April 15, 2025, **Federal Register** (90 FR 15792) (hereinafter referred to as the "April 2025 final rule"), CMS finalized several of the provisions from the proposed rule and noted the provisions of the proposed rule that would not be addressed or finalized. CMS also indicated that any remaining provisions may be finalized in subsequent rulemaking, as appropriate. For more information, see the April 2025 final rule (90 FR 15891).

II. Proposal to Format MA Organizations' Provider Directories for Medicare Plan Finder (§§ 422.111 and 422.2265) and Analysis of and Responses to Public Comments

CMS continues to take steps to improve the usability of MPF to assist beneficiaries in making informed choices about their Medicare coverage. It is important that Medicare beneficiaries have the information they need to make the best choice for their health when they are exploring their plan options. Understanding which providers are in a plan's network is a vital piece for beneficiaries to make an informed choice. Provider directories allow beneficiaries and their caregivers to weigh Medicare options and decide if a plan's network meets their needs. Beneficiaries can check a provider directory to see if their existing providers are in the plan's network and which other contracted providers are available to deliver medical care. As the

landscape of MA has evolved, CMS has implemented rules and made modifications to required materials, disclaimers, and website requirements to ensure that people with Medicare and the trusted individuals they rely on to aid in their decision making have the information necessary to make decisions about their Medicare options.

In the December 2024 proposed rule, CMS proposed additional regulatory changes to allow the agency to leverage technological methods that streamline the beneficiary experience so that beneficiaries have the provider network information they need to make the best choice for their needs. CMS proposed to make changes that would allow MA provider directory data to be viewable on MPF for the 2026 Annual Election Period (AEP). In addition, to ensure the accuracy of the data being submitted, CMS proposed that MA organizations would be required to update the provider directory data being made available to CMS for inclusion online in MPF within 30 days of receiving information from providers of a change, and to require MA organizations to attest to the accuracy of the provider directory data being submitted. In total, CMS articulated the expectation that these proposed changes, if finalized, would result in an advancement of informed beneficiary choice and transparency benefiting people with Medicare, while also promoting robust competition within the Medicare market.

Section 1851(d)(1) of the Social Security Act (the Act) states that the Secretary shall provide for activities to broadly disseminate information to current and prospective Medicare beneficiaries on MA plan coverage options to promote an active, informed selection among such options. Specifically, per section 1851(d)(2)(A)(ii) of the Act, at least 15 days before the beginning of each annual coordinated election period, the Secretary shall provide MA-eligible individuals with a list identifying the MA plans that are (or will be) available to residents of the areas in which they reside, including certain information concerning such MA plans, presented in a comparative form. This information is described in section 1851(d)(4) of the Act and includes plan benefits, premiums, service area, quality and performance indicators, and supplemental benefits. Section 1851(d)(4)(A)(vii) of the Act also sets forth that information comparing MA

plan options must specifically include the extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network. In addition, section 1851(d)(7) of the Act provides that MA organizations shall provide CMS with such information about the MA organization and each MA plan that it offers, as may be required for the preparation of the information for Medicare Open Enrollment described in section 1851(d)(2)(A) of the Act.

Section 1852(d)(1) of the Act requires access to services for MA enrollees and states that MA organizations offering an MA plan may select the providers from whom the benefits under the plan are provided if the MA organization complies with several conditions, including access to appropriate providers (section 1852(d)(1)(D) of the Act). Specifically, network-based MA plans must demonstrate an adequate contracted provider network that is sufficient to provide access to covered services in accordance with the access standards at section 1852(d)(1) of the Act. Section 422.116(a)(2) further clarifies this obligation by providing network adequacy access requirements for MA plans. Section 422.116(a)(2)(i) requires that MA organizations must attest that they have an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year.

Section 1852(c)(1)(C) of the Act further requires MA plans to disclose the number, mix, and distribution of plan providers, among other disclosures. Based on this statutory requirement, CMS has implemented regulations at § 422.111(b)(3)(i) that require MA plans to disclose the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services. These regulations establish the overarching requirements for the MA provider directory content.

The Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health

Care Providers (85 FR 25510) (hereinafter referred to as the "May 2020 Interoperability and Patient Access final rule") became effective on June 30, 2020, and required MA organizations, beginning on January 1, 2021, to make standardized information about their provider networks accessible through a Provider Directory Application Programming Interface (API) that conforms with the CMS/HHS technical standards at § 422.119(c). The May 2020 Interoperability and Patient Access final rule also included in § 422.120 that the Provider Directory API must be accessible via a public-facing digital endpoint on the MA organization's website to ensure that this information is viewable and accessible to prospective and current enrollees as well as third-party application developers, who can create services to help patients find providers for care and treatment. Requirements at § 422.120 further specify that the MA plan's directory of contracted providers must be complete and accurate and include names, addresses, phone number, specialties and (as applicable for MA-PDs) the number of pharmacies in the network and mix of pharmacy types. MA organizations must ensure this information is updated within 30 calendar days of receiving updated provider directory information. Provider Directory API technical standards were also modified for more specificity in the February 2024 Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program Final Rule (89 FR 8758), which was effective on April 8, 2024.

To comply with the previously referenced statutory and regulatory requirements, CMS has historically taken a two-pronged approach. CMS implemented MPF as an online resource where current and prospective beneficiaries and their caregivers can explore their Medicare coverage options. On MPF, individuals can look for MA and Part D plans and make informed

choices based on the information provided, such as plan benefits, premiums, deductibles, and Star Ratings, to name a few. While CMS has implemented improvements to MPF over the years to incorporate more data, MPF does not currently include information on MA plans' contracted provider networks, such as the specific providers with which a plan contracts and from which an enrollee may receive health care services.

In addition to creating MPF, CMS has implemented regulations that require each MA organization to disclose or otherwise make available certain required information, including hardcopy and electronic provider directory requirements under § 422.2267(e)(11), as well as a searchable online directory as required under § 422.2265(b)(4). Through these requirements, the provider directory information is made available to prospective and existing MA plan enrollees so they may view MA plans' in-network providers and other relevant information as required under § 422.111(b)(3)(i), such as the provider's specialty and location in the MA organization's online PDF or a printable copy of their provider directory (§ 422.2265(b)(3)). However, using MPF while also searching multiple plan websites to determine a provider's network status can be cumbersome. Prospective and current MA plan enrollees must toggle between different MA plan websites and MPF to find and review the plans' provider directories to determine if the providers they currently see are in the various plans' networks, as well as review the information provided by MPF.

In order to simplify and streamline the Medicare beneficiary shopping experience, CMS proposed to expand on the existing requirements applicable to MA organizations regarding their provider directories at a newly established § 422.111(m) to include a new paragraph that requires MA organizations to: (1) make the information described in § 422.111(b)(3)(i) available to CMS/HHS for publication online in accordance with guidance from CMS/HHS; (2) submit or otherwise make available their plan provider directory data, that is the requirements found under § 422.111(b)(3)(i), available to CMS/HHS in a format, manner, and timeframe determined by CMS/HHS; (3) update the information subject to § 422.111(m) within 30 days of the date an MA

organization becomes aware of a change; and (4) attest, in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements at § 422.116(a)(2)(i). The combined intent of the proposed requirements was to allow CMS to use the MA organization's provider directory data to be integrated online by CMS/HHS for display on MPF. As noted in the preamble of the December 2024 proposed rule (89 FR 99431) and earlier in this final rule, CMS has previously adopted regulations to implement requirements applicable to MA organizations for publicly accessible, accurate, and timely provider directory information through the May 2020 Interoperability and Patient Access final rule. The provider directory requirements of the May 2020 Interoperability and Patient Access final rule aid in establishing the groundwork for MA plan provider directory information to be readily accessible for MA organizations to submit to CMS for inclusion on MPF.

In the December 2024 proposed rule (89 FR 99432), CMS also highlighted that the requirements being proposed at 42 CFR 422.111(m) would closely mirror the provider directory submission requirements at 45 CFR 156.230(c) for Qualified Health Plan (QHP) issuers on the federally facilitated Exchange (FFE). Currently, 45 CFR 156.230(c) requires issuers seeking certification to offer QHPs on the FFE to submit provider information in a format and manner and at times determined by HHS/CMS to HHS/CMS. This information is then used to feed HealthCare.gov and its Direct Enrollment partner websites to allow consumers to filter available QHPs based on the providers and drugs covered by those QHPs. The proposed requirements for MA organizations took a substantially similar approach. Given that many health insurance carriers offer both MA plans and QHPs, CMS explained in the December 2024 proposed rule that this was a reasonable approach that would help lessen the burden associated with meeting the MA requirements. CMS also noted that the proposed requirements set forth in the December 2024 proposed rule would only apply to MA organizations (not Part D sponsors).

In response to the December 2024 proposed rule, CMS received comments from various stakeholders including advocates, health plans, providers, trade organizations, drug manufacturers, and a few individuals. The following are comments on this proposal as they pertain to the provisions, which CMS proposed to include in its regulations at § 422.111(m)(1) through (3), that would require MA organizations, including MA organizations that offer MA plans with Part D coverage, to make provider directory data available to CMS/HHS for publication online in MPF, to submit or otherwise make available their plan provider directory data available to CMS/HHS in a format, manner, and timeframe determined by CMS/HHS; and to update the information within 30 days of the date an MA organization becomes aware of a change. Note that CMS has outlined and responded to comments received regarding the related attestation requirement, which CMS proposed at § 422.111(m)(4), in a later section of this final rule.

Comment: The majority of commenters expressed support for this provision. Some commenters acknowledged that it is critical when serving some of the nation's most vulnerable patients that enrollees have dependable information about their providers. Other commenters encouraged CMS to finalize this provision because they believed it would streamline the current provider directory review process while improving transparency for beneficiaries who are navigating their healthcare options. Lastly, a commenter stated that meaningful and accurate network comparisons on MPF will greatly improve enrollment decisions as well as meaningful competition between plans.

Response: CMS agrees and thanks commenters for their feedback. The goal of this provision is to improve the plan comparison experience and help beneficiaries make an informed choice by making provider information accessible on MPF.

Comment: Several commenters expressed concerns with this proposal, stating that it failed to address key underlying causes of inaccuracy, which drive provider directory problems, and that this proposal may cause MA plans to be penalized due to circumstances beyond their

control. Specifically, when providers fail to promptly update their address, telephone number, or other provider directory information, MA plans are held accountable for inaccurate provider directories.

Response: Thank you for your comments. CMS understands the complexities that may contribute to provider directory accuracy issues. However, CMS notes that there are existing regulatory requirements to ensure provider directory accuracy, including those under §§ 422.111(a)(2), 422.2262(a)(1)(i), 422.2267(c)(1), and 422.2267(e)(11)(iv). In addition, CMS's annual CY 2026 Medicare Advantage and Section 1876 Cost Plan Provider Directory Model and Instructions, issued June 16, 2025, strongly encourages MA organizations to institute procedures that support the ongoing accuracy of their provider directory. Therefore, the MA organization retains responsibility for data accuracy through the implementation of best practices. Moreover, while the focus of this provision is not provider directory accuracy, CMS notes that including provider directory data on MPF is another tool to help provide more accurate provider directory data for Medicare beneficiaries. CMS will bear in mind the information that was provided by these commenters as CMS considers future policymaking regarding underlying provider directory accuracy issues.

Comment: Several commenters stated that the inclusion of the information on MPF would be redundant since provider directories were already available on plan websites and there were already requirements to inform beneficiaries when changes to networks occurred.

Response: With regard to the concerns expressed associated with redundancy of effort, CMS acknowledges that there are other provider directory requirements such as those that MA organizations provide their members with a provider directory (§ 422.2267(e)(11)) and make provider directories accessible on plan websites (§ 422.2265(b)(4)). However, while prospective enrollees can view this information on individual plan websites, without a central repository of provider directory information across all MA plans, it is not easy for beneficiaries to compare networks among various MA plan choices. As such, CMS notes that any redundancy is offset by

the benefit of complete and meaningful provider network comparisons made possible by inclusion of this directory information in MPF, so that beneficiaries may more readily consider and choose the best plan for their health care needs.

Comment: Some commenters raised concerns regarding operational guidance as it pertains to the timing and implementation of this provision. A few commenters expressed their concerns about receiving guidance early enough to allow ample time to prepare before MA organizations are required to submit their provider directory data to CMS. Additionally, a few commenters requested clearer guidance pertaining to provider directory content and MA organization networks. More specifically, a commenter requested that CMS clarify the provider types that must be included in the provider directory and whether the requirements will be consistent across plans. Another commenter questioned whether the provider directory information that will be included in MPF would pertain solely to providers in the plans' service area or whether the information would also include providers covered under travel benefits. Regarding the plan's network, a commenter questioned if the plan-provided information to CMS supersedes the delegated entity when inconsistencies in the plan's network arise. Lastly, several other commenters inquired about the process for updating submitted provider data and whether there will be a pilot program to validate such submissions.

Response: To ensure that MA plans have sufficient time to implement these provider directory requirements, CMS intends to issue an operational guide soon after the publication of this final rule. CMS anticipates that the operational guide will include technical information about how MA plans will format and submit the provider directory data files for purposes of this new regulatory requirement. The January 1, 2026, applicability date is the date by which plans will be required to conform with the new requirements in § 422.111(m) by making their provider directory data available to CMS; however, this data may not be accessible to the public on MPF by January 1, 2026. Additionally, CMS intends to offer technical support prior to January 1, 2026, as well as a testing period prior to having the new MPF functionality available to Medicare

beneficiaries, to provide technical feedback to MA organizations in the period before they are expected to comply with these new requirements. The testing period will allow the parties to test that the directory data made available to Medicare beneficiaries through MPF reflects the data that the MA organizations provided.

With respect to the information regarding which providers are considered network providers for the purposes of inclusion in the provider directory and submitted to CMS, provider types required for inclusion are outlined annually in the Medicare Advantage and Section 1876 Cost Plan Provider Directory Model and Instructions. For example, the 2026 instructions can be found at https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/models-standard-documents-educational-materials. CMS also regularly provides MA plans with a provider directory model that contains required content to ensure consistency among plans. The current provider directory requirements at §§ 422.111(b)(3) and 422.2267(e)(11) do not include providers outside of their network (for example, traveling providers); therefore, the provider directory data that is submitted for publication online in MPF should mimic these requirements and exclude out-of-network travel providers.

Regarding the commenter's inquiry about whether plan-provided information to CMS supersedes a delegated entity when inconsistencies in the plan's network arise, CMS is interpreting this question to be about discrepancies between an MA plan and a provider as it applies to the accuracy of the provider network data required at §§ 422.111 and 422.2262(a). CMS's focus is on accuracy as it applies to a beneficiary enrolled in an MA plan being able to identify, contact, and schedule an appointment with providers within that MA plan's network in question. For example, if a provider office was not aware that they were in the plan's network and were telling enrollees of the plan that they cannot make an appointment, the "who is right" is irrelevant, as the outcome is that the beneficiary is unable to make an appointment. CMS views the MA organization's contracted provider to be a first-tier entity, and hence the responsibility of

the MA organization per § 422.504(i)(1). Ultimately, it is up the MA organization to determine how best to work with providers to meet the requirements for accurate provider directories.

Comment: Commenters provided technical input on how they believe provider directory data should be formatted once it is incorporated into MPF. Overall, commenters requested that CMS require the collection of the provider directory data in a format similar to that which is currently used. A few commenters requested that CMS build machine-readable JavaScript Object Notation (JSON) files, which are currently used by health plans on the Health Insurance Marketplace, while others requested that CMS not establish additional reporting formats and utilize only the application programming interface (API) specifications used under the existing May 2020 Interoperability and Patient Access final rule.

Other commenters provided more general comments pertaining to how they would like provider directory data displayed in MPF. Some commenters expressed that they want real-time updates that display provider network comparisons on a simplified interface using basic language and advanced filtering options to narrow down choices.

Response: CMS appreciates the input from commenters. As discussed, CMS intends to develop and distribute an operational guide with details such as file formatting so plans have the resources available in advance to ensure compliance with this provision. Additionally, CMS understands the preference for utilizing established reporting formats like the API. As previously mentioned, the technical details for implementation will be provided as a part of operational guidance. CMS appreciates the suggestion that the provider directories on MPF include real-time updates. CMS reiterates that § 422.111(m)(3) of this provision requires that the data being made available for use in populating MPF be updated within 30 days of the date an MA organization becomes aware of a change. As noted, this requirement mirrors existing requirements for provider directories. Through operational guidance, CMS will also provide more detail on how quickly those changes are reflected on MPF.

After carefully reviewing and responding to all comments as they pertain to proposed § 422.111(m)(1) through (3), CMS is finalizing these requirements as proposed.

In the December 2024 proposed rule (89 FR 99432) CMS noted that, while publishing MA plan provider directory information on MPF is an important step, doing so in a way that ensures that beneficiaries are accessing accurate information is a critical part of improving the Medicare beneficiary experience while using MPF. In order to enhance the accuracy of the information that will be published online by CMS/HHS on MPF, CMS proposed to add new § 422.111(m)(4), which would require an MA organization to attest in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements at § 422.116(a)(2)(i). Given the significance of the choice that a beneficiary is making based on the information provided by the MA organization, CMS asserted in the proposal that it was critical to include this attestation requirement to ensure that the information being submitted by MA organizations is accurate and consistent with data submitted to comply with CMS's MA network adequacy criteria when it is submitted to CMS for the purpose of incorporating it into MPF. The December 2024 proposed rule stated that it was imperative that MA organizations' provider directory data remains consistent with the contracted provider network data submitted to CMS to provide sufficient access to covered services (89 FR 99432).

However, regarding the attestation, because provider directory data changes so frequently, CMS acknowledged in the December 2024 proposed rule that it may be impractical to require an attestation with each update. In the proposed rule, CMS stated that the agency was considering how to best balance the need for accountability of accurate data with the burden of the attestation. CMS stated that, if this proposed rule was finalized, CMS would provide operational guidance that would explain how the attestation process would be implemented. CMS also stated in the December 2024 proposed rule that the agency envisioned an attestation

taking place when the data is first made available to CMS, and then a yearly attestation thereafter (89 FR 99432). CMS requested feedback on the attestation process, including the intervals for the attestation and received the following comments in response.

Comment: Some commenters mentioned that the attestation requirement would increase the accountability of MA organizations, which would reduce inaccurate provider directories that have contributed to reduced access to services. Another commenter believed that requiring an attestation was a great first step in helping to eliminate "ghost networks" — providers listed in directories who were not actually contracted with the MA plan. Other commenters did not support the attestation requirement, citing that MA plans would be held accountable for provider directory errors even though providers input the source data. Commenters also feared that additional reporting requirements and penalties could increase burden and compliance actions. As a result, a commenter requested that CMS define accuracy and its parameters, as CMS proposed to require an attestation to ensure that the information being submitted by MA organizations was accurate and consistent with data submitted to comply with CMS's MA network adequacy criteria. Several other commenters offered suggestions on how to improve overall provider directory accuracy. Some suggestions included allowing MA plans to demonstrate the adequacy of their networks through provider claims data and requiring MA plans to use an independent third-party verification company to confirm their provider directory information met a minimum accuracy threshold.

Response: CMS thanks commenters for their support regarding the provider directory data attestation requirement. The agency also acknowledges the concern expressed through comments regarding additional burden and potential compliance problems. CMS notes that MA plans are required to have accurate provider directories and maintain compliance with existing regulatory accuracy requirements that include: (1) disclosure requirements under § 422.111(a)(2), which mandate that MA organizations provide information in a clear, accurate, and standardized format; (2) provider directory access requirements at § 422.120(b), which

require MA organizations' APIs to maintain complete and accurate directories of their contracted provider networks updated within 30 calendar days of receiving provider directory changes; (3) general communication requirements under § 422.2262(a)(1)(i), ensuring that all provided information is neither misleading nor inaccurate; and (4) required materials regulations at § 422.2267(c)(1) and (e)(11)(iv) that require MA organizations to accurately convey essential information and promptly update provider directory data upon becoming aware of any changes.

After careful consideration of all comments received associated with the proposed attestation requirement under § 422.111(m)(4), CMS is finalizing the portion of the attestation proposal that requires MA organizations to attest, in a format and manner and at times determined by CMS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) be accurate. CMS is finalizing this part of its regulation with one modification, to make clear that at a minimum, MA organizations will be required to attest at least annually. Additional details about the format, manner, and timing/frequency of such attestation will be provided in the operational guidance.

CMS has decided not to finalize the portion of the proposed attestation requirement that would require MA organizations to attest that their provider directory data is consistent with data submitted to meet CMS's MA network adequacy requirements at § 422.116(a)(2)(i). CMS has determined it is more appropriate to distinguish provider directory accuracy from network adequacy for this purpose. CMS notes that MA organizations have separate obligations to ensure network adequacy and already attest that they have an adequate network for access and availability of a specific provider or facility type. CMS believes that an attestation submitted at least annually and specifically addressing the provider directory data would work in conjunction with the existing regulatory accuracy requirements to further strengthen data accuracy and enhance CMS's ability to ensure reliable provider directory data for beneficiaries. In addition, to strike a balance between burden and accountability, CMS intends to collect the attestation at

least annually, at a timeframe prior to the AEP. Further details will be provided in the previously mentioned operational guidance.

The provider directory data attestation will complement CMS's existing regulatory accuracy requirements, oversight mechanisms, and compliance monitoring through the current regulatory framework established under §§ 422.111, 422.2262(a), and 422.2267(e)(11), all of which will allow CMS to maintain accountability for provider directory accuracy, including addressing "ghost networks" and other issues referenced by commenters. CMS encourages MA plans to continue working with providers and exploring other options to maintain clear, current, and accurate provider directories.

Comment: A few commenters provided comments associated with the timing of the effective date and rollout of these requirements, as well as when CMS is expecting the required data to be available to beneficiaries on MPF. A few commenters suggested delaying implementation of this provision due to timing and burden concerns. Specifically, commenters stated that implementation of this provision could require substantial financial and resource investments resulting in financial burden. Additionally, another commenter mentioned the administrative burden of having to attest with each data update while implementing other provider directory requirements and rushing implementation due to short timeframes. However, the commenters did not provide any specifics to further elaborate on the concerns associated with financial or administrative burdens associated with this rule. Commenters did suggest alternative implementation dates from as early as the 2027 AEP (October 15, 2026) to as late as July 1, 2028, which is 3 months before the 2029 AEP, to allow plans to fully comply.

Response: CMS appreciates the commenters' suggestions regarding the effective date of the policy and alternative implementation dates. In the December 2024 proposed rule, CMS stated that in order to operationalize the proposed Format Provider Directories for Medicare Plan Finder provision at § 422.111(m), the agency anticipated that 2025 plan year provider directory data would need to be made available online for testing purposes in the summer of 2025, and

2026 plan year data would need to be available online on October 1, 2025. Therefore, an applicability date of July 1, 2025, was proposed for this provision (89 FR 99340). However, CMS has delayed the finalization of this provision to allow for further consideration of the impacts and burden on plans and providers. As such, because this provision was not finalized in the April 2025 final rule, CMS notes that the anticipated implementation timeline discussed in the preamble of the December 2024 proposed rule should also be adjusted. CMS is therefore finalizing an applicability date of January 1, 2026, meaning this is the date by which MA organizations will have to have directory data available to CMS. As stated in a previous response to a comment regarding provider directory formatting, CMS intends to publish an operational guide to allow MA plans to familiarize themselves with formatting and technical submission requirements before the implementation date. Therefore, CMS does not anticipate that MA plans will need 2 years from the new applicability date to fully comply with these requirements. Prior to January 1, 2026, as well as prior to having the new MPF functionality available to Medicare beneficiaries, CMS will also provide a period of time where MA organizations can raise questions and where CMS will work with MA plans to format their provider directory data as specified in the operational guide. CMS will also provide time for MA organizations to test their data with CMS. Additionally, proposed provisions at § 422.111(m) will be finalized with one modification to exclude the portion of the proposed attestation requirement within § 422.111(m)(4) that required MA organizations to attest that provider directory information is consistent with data submitted to comply with CMS's MA network adequacy requirements at § 422.116(a)(2)(i). This modification is expected to decrease the administrative burden on MA organizations relative to CMS's original proposal, as the modified policy now requires MA organizations to only attest that their submitted provider directory data is accurate.

Finally, CMS received a number of comments that touched on provider directory data more generally, including provider directory data accuracy. While not the focus of the December 2024 proposed rule, accurate provider directories remain an important focus for CMS.

Comment: In an effort to ensure that provider directories are comprehensive and include all providers available to beneficiaries, some commenters recommended including additional health care providers such as physician assistants (under the specialty in which they practice), individuals providing supplemental benefits, and clinicians and their affiliated clinic types. A commenter also requested that provider capabilities specific to cultural competence be identified in the provider directory. Alternatively, a few commenters suggested excluding providers if they have given notice of their intent to terminate their contractual relationship or if the MA organization cannot verify their provider directory data or have no confidence in the information they have obtained.

Response: CMS thanks commenters and acknowledges their recommendations to ensure that provider directories reflect all providers who are available to provide health care services for enrollees of a given MA plan. CMS notes that existing regulations require that an MA organization have written policies and procedures for selecting and evaluating the contracted providers in its network, including ensuring that these providers meet applicable credential requirements (42 CFR 422.204). In accordance with this requirement, through the subsequent operational guide, CMS will provide the technical format that the provider directory data will need to take to ensure that the required elements of the provider directory under §§ 422.111(b)(3) and 422.2267(e)(11) will be accurately reflected in MPF. Additionally, CMS notes that existing MA regulations at § 422.111(b)(3)(i) require that MA organizations disclose in provider directories each provider's cultural and linguistic capabilities, including languages such as American Sign Language, offered by the provider or a qualified medical interpreter at the provider's office. With regard to comments that seek to exclude providers due to an impending contract termination or lack of verifiable data, CMS expects that the data provided to the agency

will be updated as necessary to ensure that MA organizations remain compliant with provider directory accuracy requirements including §§ 422.111(a)(2), 422.120(b)(1), 422.2267(e)(11)(iv)(A), and the requirement at § 422.111(m)(3) newly finalized by this final rule.

Comment: Commenters suggested that provider directory monitoring, compliance, and enforcement include performing random provider directory audits and secret shopper surveys, incorporating provider directory attestation compliance in the Star Rating methodology, and canceling MA plan contracts for non-compliance or imposing financial penalties. Several commenters encouraged CMS to collaborate with external stakeholders to ultimately improve provider directory accuracy by focusing on public-private partnerships between the federal government, providers, payers, and solutions vendors to streamline and improve provider directory accuracy while also strengthening transparency and enhancing data workflows through additional collaborations with trade organizations and HL7.

Response: CMS believes that these comments are out of scope for this rulemaking. However, CMS appreciates the commenters' suggestions and will consider these and other recommendations during future rulemaking. CMS acknowledges commenters' recommendations to collaborate with external stakeholders as CMS recognizes the value in working together to achieve a common goal of improving a beneficiary's experience while using MPF, which will result in informed beneficiary choice, transparency, and increased access to health care.

CMS thanks commenters for their suggestions on how the agency can improve the overall accuracy of provider directories. CMS remains open to receiving suggestions to improve provider directory accuracy and will consider these recommendations for future rulemaking.

In summary, after carefully considering all of the comments, CMS is finalizing the following provider directory requirements at § 422.111(m) as proposed: that MA organizations must, for plan years beginning on or after January 1, 2026, (1) make the information described in § 422.111(b)(3)(i) available to CMS/HHS for publication online in accordance with guidance

from CMS/HHS; (2) submit, or otherwise make available, the information described in § 422.111(b)(3)(i) to CMS/HHS in a format and manner and at times determined by CMS/HHS; and (3) update the information subject to paragraph (m) within 30 days of the date an MA organization becomes aware of a change.

With regard to CMS's proposed regulation text at § 422.111(m)(4), that MA organizations must attest in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements at § 422.116(a)(2)(i), for the reasons outlined previously in this preamble, CMS will not be finalizing this requirement as proposed. Instead, CMS is finalizing only the portion of the proposed requirement that MA organizations must attest, in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) is accurate. In addition, as discussed above, CMS is finalizing this requirement with one modification to provide that this attestation must occur at least annually.

As discussed previously in this final rule, the requirements described herein are applicable to MA organizations beginning January 1, 2026. This means that MA organizations will be required to make their directory data available to CMS by January 1, 2026, however, it does not mean that the data will be available on Medicare Plan Finder (MPF) for use by the public by January 1, 2026. CMS expects a period of testing to take place to ensure that the directory data made available to Medicare beneficiaries through MPF accurately reflects the data provided by MA organizations. As noted earlier in this final rule, the agency plans to release an operational guide soon after the publishing of this final rule. The operational guide will outline technical specifications and milestones by which MA organizations' provider directory data will be made available for CMS so that it can later be made available to beneficiaries by way of MPF.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), CMS is required to provide notice in the **Federal Register** and solicit public comment before a "collection of information," as defined under 5 CFR 1320.3(c) of the PRA's implementing regulations, is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection requirement should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that CMS solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of the estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In our December 10, 2024 (89 FR 99340) proposed rule (CMS-4208-P; RIN 0938-AV40), CMS solicited public comment on a number of proposed information collection requirements.

While a number of requirements were finalized on April 15, 2025 (90 FR 15792) under CMS-4208-F (RIN 0938-AV40), the proposed information collection requirement in section VI.B.12 of the proposed rule (89 FR 99503) titled "ICRs Regarding Formatting Medicare Advantage (MA) Organizations' Provider Directories for Medicare Plan Finder (§422.120(c))" was not included at that time. As indicated throughout this preamble, this provision is being finalized in this rule.

CMS received a PRA-related comment on the proposed provisions, which is summarized in section III.B. of this final rule.

A. Wage Data

For the purpose of the programming necessary to provide CMS with the provider directory data, CMS estimates that a member of an MA organization's Information Technology staff will require an average of 8 hours. This is a one-time instance. For the purpose of completing the attestation, CMS expects that an MA organization's plan officer will require 1 hour annually. The hourly wage data for both these MA organizations' staff persons are reflected in Table 2. The calculation of the one-time burden estimates for the creation of the programming necessary to provide CMS with provider directory data is in Table 3. The calculation of the annual burden estimate for the plan officer attestation is in Table 4.

To derive average (mean) costs, CMS is using data from the most current U.S. Bureau of Labor Statistics' (BLS's) National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/2024/may/oes_nat.htm), which, at the time of publication of this final rule, provides May 2024 wages. In this regard, table 2 presents BLS's mean hourly wage, CMS's estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and CMS's adjusted hourly wage.

TABLE 2: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupational Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Computer Programmer	15-1251	49.83	49.83	99.66
Plan Officer (CEO, CFO, COO, CTO)	11-1011	126.41	126.41	252.82

Adjusting CMS's employee hourly wage estimates by a factor of 100 percent is a rough adjustment that is used since fringe benefits and other indirect costs vary significantly from employer to employer and because methods of estimating these costs vary widely from study to study. In this regard, CMS believes that doubling the hourly wage to estimate costs is a reasonably accurate estimation method.

B. Information Collection Requirements (ICRs) Regarding Formatting MA Organizations' Provider Directories for Medicare Plan Finder (§ 422.111(m))

The proposed rule inadvertently indicated (89 FR 99503) that the proposed collection of information request (CMS-10906) would be submitted to OMB for review. This rule corrects that statement which should have indicated that the collection of information request (CMS-10906, OMB control number 0938-TBD) will be made available for public review and comment using the standard non-rule PRA process which consists of publishing 60- and 30-day notices in the **Federal Register** before the collection of information request is submitted to OMB for their review/approval. CMS expects that the initial 60 day notice will publish sometime after the final rule. The PRA package associated with this burden will include a supporting statement, a clearance sheet, the language CMS expects to use for the attestation process, and further detail on the guidance that will instruct plans on how to operationalize CMS access the plan's provider data.

As indicated in section II. of this final rule, CMS is finalizing proposed requirements at § 422.111(m) for MA organizations to submit MA provider directory data to CMS/HHS for use in MPF. Under this provision, MA organizations are required to: (1) make the information described in § 422.111(b)(3)(i) available to CMS/HHS for publication online in accordance with guidance from CMS/HHS; (2) submit, or otherwise make available, the information described in § 422.111(b)(3)(i) to CMS/HHS in a format and manner and at times determined by CMS/HHS; (3) update the information subject to § 422.111(m) within 30 days of the date an MA organization becomes aware of a change; and (4) Attest at least annually, in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under paragraph (m) is accurate. CMS believes this would further the agency's objective to promote informed beneficiary choice, efficiency, and transparency.

Even though the reporting of provider directory data and updated directory data by MA organizations to CMS is ongoing, it is part of an automated process that is expected to take 8

hours at $99.66/hr for a computer programmer for each plan to create the functionality within their system.

In aggregate, CMS estimates a one-time burden of 5,600 hours (700 plans * 8 hr./plan) at a cost of $558,096 (5,600 hr. * $99.66/hr). This is a measure of the burden of the programming changes necessary to provide CMS access to the provider directory data.

TABLE 3: ONE-TIME INITIAL BURDEN ESTIMATES

Regulation Section(s) under Title 42 of the CFR	Respondents	Responses (per respondent)	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)
422.111(m)	700	1	700	8	5,600	99.66	558,096

CMS further estimates an annual burden of 700 hours (700 plans * 1 hr./plan) at a cost of $176,974 (700 hr. * $252.82/hr.). This is a measure of the burden of the attestation requirement.

TABLE 4: ANNUAL BURDEN ESTIMATES

Regulation Section(s) under Title 42 of the CFR	Respondents	Responses (per respondent)	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)
422.111(m)	700	1	700	1	700	252.82	176,974

In the December 2024 proposed rule, CMS used 2024 data which reflected 761 plans, including local and regional CCP, MSA, and PFFS plans. CMS also used the adjusted hourly rate of $103.60/hr, based on BLS' May 2023 mean hourly wage for a computer programmer. In this final rule, the agency is updating the number of plans to 700 and the adjusted hourly wage to $99.66/hr, based on the most currently available data. As a result, the total cost estimate has decreased by $72,621 (from $630,717 to $558,096).

The 700 plans include local and regional CCP, MSA, and PFFS plans and is based on the publicly available CMS data on plan type counts accessible at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-contract-and-enrollment-summary-report/contract-summary-2025-05. Medicare Cost plans have been excluded from the count since the ultimate goal of the provision is a display in MPF, and MPF does not currently list Medicare Cost plans.

As the agency is including an attestation requirement for the rule, CMS calculates that an officer at each of the 700 plans mentioned previously will have to spend one hour attesting to the accuracy of the plan's provider directory data. BLS's National Occupational Employment and Wage Estimates indicate an hourly wage of $126.41 adjusted per the calculations mentioned earlier in this section to $252.82. To this end, 700 respondents x 1 hour per respondent x an hourly wage of $252.82 equals $176,974 in annual burden for the plan officer annual attestation.

As noted, in response to the December 2024 proposed rule CMS received the following comment regarding the estimates provided.

Comment: A commenter questioned CMS's proposed level of effort for programmers responsible for submitting provider directory data as required by this provision. The commenter stated that 8 hours for programming is lower than what is required for simple updates and much less than what is required for the generation of new reports in most IT departments.

Response: Thank you for your comment. Given that the commenter did not include any additional data or updated timeframes provided in support of their claim of inadequate programming hours, combined with CMS not receiving any other comments expressing such concerns, the 8-hour programming time will remain unchanged. Additionally, CMS's May 2020 Interoperability and Patient Access final rule, which establishes some of the groundwork for this requirement previously established the estimated costs associated with putting provider directory data in an electronic format. Moreover, CMS expects the ongoing cost associated with this requirement to be negligible given that MA organizations are currently required to provide and maintain accurate electronic provider directories, which must be updated, as required at § 422.2267(e)(11)(iv), within 30 days of learning of a change.

After considering the comment received, CMS is not making any additional changes to these estimates.

IV. Regulatory Impact Analysis

A. Statement of Need

CMS continues to take steps to improve the usability of MPF to assist beneficiaries in making informed choices about their Medicare coverage. It is important that Medicare beneficiaries have the information they need to make the best choice for their health when they are exploring their plan options. Understanding which providers are in a plan's network is a vital piece for beneficiaries to make an informed choice. Provider directories allow beneficiaries and their caregivers to weigh Medicare options and decide if a plan's network meets their needs. Beneficiaries can check a provider directory to see if their existing providers are in the plan's network and which other contracted providers are available to deliver medical care. While CMS has implemented improvements to MPF over the years to incorporate more data, MPF does not currently include information on MA plans' contracted provider networks, such as the specific providers with which a plan contracts and from which an enrollee may receive health care services.

The combined intent of the final rule is to allow CMS to use the MA organization's provider directory data to be integrated online by CMS/HHS for display on MPF and for this data to be accurate. This will allow MPF users to have access to MA plans' provider directory data when comparing MA plan information on MPF and for that comparison to be meaningful. As a result, MPF users will save the time they would have used going to multiple MA organization websites to access provider directories.

The primary purpose of this final rule is to amend the regulations pertaining to disclosure requirements under § 422.111 for the MA program. CMS is finalizing a new requirement that will increase beneficiaries' access to provider data when comparing plans in the CMS Medicare Plan Finder (MPF) tool, which will contribute to the beneficiaries' ability to make more informed decisions about their health care. In addition, CMS is finalizing the proposal that MA provider directory data be updated within 30 days of the date an MA organization becomes aware of changes to that data and requires MA organizations to attest at least annually that the MA provider directory data are accurate.

B. Overall Impact Analysis

CMS has examined the impacts of this rule as required by Executive Order 12866, "Regulatory Planning and Review"; Executive Order 13132, "Federalism"; Executive Order 13563, "Improving Regulation and Regulatory Review"; Executive Order 14192, "Unleashing Prosperity Through Deregulation"; the Regulatory Flexibility Act (RFA) (Pub. L. 96-354); section 1102(b) of the Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts.). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. This final rule does not meet the threshold required to be considered significant under section 3(f)(1) of E.O.12866.

As outlined in the preamble, the regulatory changes in this final rule will further promote informed beneficiary choice and transparency found in online resources, empowering people with Medicare to make informed choices about their coverage. CMS is finalizing a new requirement that will increase beneficiaries' access to provider data when comparing plans in the

MPF tool, which will contribute to the beneficiaries' ability to make more informed decisions about their health care. This will allow MPF users to have access to MA plans' provider directory data when comparing MA plan information on MPF and for that comparison to be meaningful. As a result, MPF users will save the time they would have used going to multiple MA organization websites to access provider directories. CMS believes that the cost for MPF users undertaking administrative and other tasks on their own time is a post-tax wage of $29.80/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for MPF users, a measurement of the usual weekly earnings of wage and salary workers of $1,192, divided by 40 hours to calculate an hourly pre-tax wage rate of $29.80. CMS used this figure to estimate the benefit of this final rule regarding time saved by MPF users from using the new functionality of MPF rather than going to multiple websites to collect provider directory information.

TABLE 5: MPF USER WAGES

Occupational Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Average Beneficiary	00-0000	29.80	N/A	29.80

TABLE 6: BENEFIT TO MPF USERS

Benefit	Respondents	Responses (per respondent)	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)
MPF User Benefit	4,000,000	1	4,000,000	0.5	2,000,000	24.73	-49,460,000

While CMS did not receive any comments on the impact on beneficiaries in the December 2024 proposed rule, the purpose of the rule implies that there is an additional reduction in burden to the beneficiary. Because each beneficiary's experience using MPF is unique, calculating the time saved using MPF to compare MA plans using provider names as search criteria can be done in the abstract, using estimates.

CMS data shows that approximately 8 million unique users accessed MPF in 2023, which resulted in about 2 million MA enrollments. For the purpose of this rule, CMS estimates 4 million MPF users visited individual plan websites to compare provider directory data for at least one provider. Furthermore, the time saved can be estimated at approximately 30 minutes (0.5 hours) per MPF user. In this final rule, the agency is using BLS's National Occupational Employment and Wage Estimates to establish a base wage of $24.73. The base wage of $24.73 x 0.5 hours x the number of users (4,000,000) equals a savings of $49,460,000.

C. Alternatives Considered

One possible alternative to requiring plans to make their provider directory data available to CMS/HHS to publish online would be to purchase that same data from a third-party vendor who has collected that data. As discussed in the August 25, 2025 "Updates to the Contract Year 2026 Medicare Plan Finder and Medicare.gov" Health Plan Management System memorandum[1], CMS has adopted this alternative as a short-term solution to provide Medicare beneficiaries provider directory data on MPF for the 2026 calendar year. However, the agency does not see this as a viable long-term solution. MA organizations are under no obligation to provide their provider directory data to a third-party vendor, nor is there a requirement that they attest to the data's accuracy when providing it to a third-party. The requirements finalized in this rule will provide CMS direct access to comprehensive provider directory data for all MA organizations, including an attestation to its accuracy for CMS to then publish online. Additionally, having the provider directory data provided directly to CMS from MA organizations is a more cost-effective solution to getting this important information published online on MPF.

The RFA, as amended, requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For

[1] https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/updates-contract-year-2026-medicare-plan-finder-and-medicaregov.

purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions.

CMS believes this final rule will have a direct economic impact on beneficiaries and MA plans. Based on the size standards set by the Small Business Administration (SBA) effective March 17, 2023, (for details, see the Small Business Administration's Web site at https://www.sba.gov/document/support-table-size-standards), Direct Health and Medical Insurance Carriers, classified using the NAICS code 524114, have a $47 million threshold for "small size." Many Medicare Advantage plans (about 30 to 40 percent) are not-for-profit, automatically classing them as "small entities" by the definitions found in the RFA. The SBA categorizes firms with 1,300 employees or fewer in this industry as small. Again, we believe the vast majority of businesses operating in this field would be considered small.[2]

The analysis in this rule provides descriptions of the statutory provisions, identifies the policies, and presents rationales for our decisions. The analysis discussed in this section and throughout the preamble of this final rule constitutes our RFA analysis. The RFA does not define the terms "significant economic impact" or "substantial number." The SBA advises that this absence of statutory specificity allows what is "significant'' or ''substantial'' to vary, depending on the problem that is to be addressed in the rulemaking, the rule's requirements, and the preliminary assessment of the rule's impact. Nevertheless, HHS typically considers a "significant economic impact" to be 3 to 5 percent or more of the affected entities' costs or revenues, and a "substantial number" to mean 5 percent or more of affected small entities within a given industry. Individuals and states are not included in the definition of a small entity.

To explain the agency's position, we will first note certain operational aspects of the MA program. Section 1851(d)(1) of the Act states that the Secretary shall provide for activities to

2 The estimates of firms within the size thresholds described in this paragraph comes from a review of data from: US Census Bureau, "2022 SUSB Annual Data Tables by Establishment Industry," <https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html>, accessed on July 25, 2025.

broadly disseminate information to current and prospective Medicare beneficiaries on MA plan coverage options to promote an active, informed selection among such options. Specifically, per section 1851(d)(2)(A)(ii) of the Act, at least 15 days before the beginning of each annual coordinated election period, the Secretary shall provide MA-eligible individuals with a list identifying the MA plans that are (or will be) available to residents of the areas in which they reside, including certain information concerning such MA plans, presented in a comparative form. This information is described in section 1851(d)(4) of the Act and includes plan benefits, premiums, service area, quality and performance indicators, and supplemental benefits. Section 1851(d)(4)(A)(vii) of the Act, also sets forth that information comparing MA plan options must specifically include the extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network. In addition, section 1851(d)(7) of the Act provides that MA organizations shall provide CMS with such information about the MA organization and each MA plan that it offers, as may be required for the preparation of the information for Medicare Open Enrollment described in section 1851(d)(2)(A) of the Act.

Section 1852(d)(1) of the Act requires access to services for MA enrollees and states that MA organizations offering an MA plan may select the providers from whom the benefits under the plan are provided if the MA organization complies with several conditions, including access to appropriate providers (section 1852(d)(1)(D) of the Act). Specifically, network-based MA plans must demonstrate an adequate contracted provider network that is sufficient to provide access to covered services in accordance with the access standards at section 1852(d)(1) of the Act. Section 422.116(a)(2) further clarifies this obligation by providing network adequacy access requirements for MA plans. Section 422.116(a)(2)(i) requires that MA organizations must attest that they have an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year.

Section 1852(c)(1)(C) of the Act further requires MA plans to disclose the number, mix, and distribution of plan providers, among other disclosures. Based on this statutory requirement,

CMS has implemented regulations at § 422.111(b)(3)(i) that require MA plans to disclose the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services. These regulations establish the overarching requirements for the MA provider directory content.

The Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (85 FR 25510) (hereinafter referred to as the "May 2020 Interoperability and Patient Access final rule") became effective on June 30, 2020, and required MA organizations, beginning on January 1, 2021, to make standardized information about their provider networks accessible through a Provider Directory Application Programming Interface (API) that conforms with CMS/HHS technical standards at § 422.119(c). The May 2020 Interoperability and Patient Access final rule also included in § 422.120 that the Provider Directory API must be accessible via a public-facing digital endpoint on the MA organization's website to ensure that this information is viewable and accessible to prospective and current enrollees as well as third-party application developers, who can create services to help patients find providers for care and treatment. Requirements at § 422.120 further specify that the MA plan's directory of contracted providers must be complete and accurate and include names, addresses, phone numbers, specialties and (as applicable for MA-PDs) the number of pharmacies in the network and mix of pharmacy types. MA organizations must ensure this information is updated within 30 calendar days of receiving updated provider directory information. Provider Directory API technical standards were also modified for more specificity in the February 2024 Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP)

Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program Final Rule (89 FR 8758), which was effective on April 8, 2024.

CMS implemented MPF as an online resource where current and prospective beneficiaries and their caregivers can explore their Medicare coverage options. On MPF, individuals can look for MA and Part D plans and make informed choices based on the information provided, such as plan benefits, premiums, deductibles, and Star Ratings, to name a few. While CMS has implemented improvements to MPF over the years to incorporate more data, MPF does not currently include information on MA plans' contracted provider networks, such as the specific providers with which a plan contracts and from which an enrollee may receive health care services.

In addition to creating MPF, CMS has implemented regulations that require each MA organization to disclose or otherwise make available certain required information, including hardcopy and electronic provider directory requirements under § 422.2267(e)(11), as well as a searchable online directory as required under § 422.2265(b)(4). Through these requirements, the provider directory information is made available to prospective and existing MA plan enrollees so they may view MA plans' in-network providers and other relevant information as required under § 422.111(b)(3)(i), such as the provider's specialty and location in the MA organization's online PDF or a printable copy of their provider directory (§ 422.2265(b)(3)). However, using MPF while also searching multiple plan websites to determine a provider's network status can be cumbersome. Prospective and current MA plan enrollees must toggle between different MA plan websites and MPF to find and review the plans' provider directories to determine if the providers they currently see are in the various plans' networks, as well as review the information provided by MPF.

As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this final rule. Therefore, the Secretary has certified that this final rule will not have a significant economic impact on a substantial number of small entities.

As outlined in the preceding Collection of Information Requirements section of this regulation, we have quantified a one-time burden cost of $558,000, based on analysis of 700 entities, which results in a per-entity cost of $797. Furthermore, we have determined the annual ongoing burden cost to be $176,974, yielding a per-entity cost of approximately $253. Both the initial per-entity cost of approximately $797 and the annual ongoing cost of $253 are substantially below the 3 to 5 percent threshold that HHS typically uses when determining if a rule will have a significant impact on a substantial number of small entities. Therefore, the Secretary has certified that this final rule will not have a significant economic impact on a substantial number of small entities.

D. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. This final rule would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any one year.

E. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This final rule does

not impose substantial direct requirement costs on state and local governments, preempt state law, or otherwise elicit Federalism implications.

F. E.O. 14192, "Unleashing Prosperity Through Deregulation"

Executive Order 14192, titled "Unleashing Prosperity Through Deregulation" was issued on January 31, 2025, and requires that "any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations." This final rule is neither an E.O. 14192 regulatory action (nor an E.O. 14192 deregulatory action) because it imposes no more than *de minimis* costs.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 16, 2025.

List of Subjects in 42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 422 as set forth below:

PART 422—MEDICARE ADVANTAGE PROGRAM

1. The authority for part 422 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w-21 through 1395w-28, and 1395hh.

2. Section 422.111 is amended by adding paragraph (m) to read as follows:

§ 422.111 Disclosure requirements.

* * * * *

(m) *Increasing consumer transparency*. For plan years beginning on or after January 1, 2026, MA organizations must do all of the following:

(1) Make the information described in paragraph (b)(3)(i) of this section available to CMS/HHS for publication online in accordance with guidance from CMS/HHS.

(2) Submit, or otherwise make available, the information described in paragraph (b)(3)(i) of this section to CMS/HHS in a format and manner and at times determined by CMS/HHS.

(3) Update the information subject to this paragraph (m) within 30 days of the date an MA organization becomes aware of a change.

(4) Attest at least annually, and in a format and manner and at times determined by CMS/HHS, that all information submitted or otherwise made available to CMS/HHS under this paragraph (m) is accurate.

Robert F. Kennedy, Jr.

Secretary,

Department of Health and Human Services.

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