



Shaping Healthcare Possibilities

# Navigating the CMS Provider Data Mandate

Turning directory accuracy into a strategic driver  
of patient choice



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Provider directories have long been one of the weakest links in U.S. healthcare data management. Despite regulatory requirements, most Medicare Advantage (MA) organizations still rely on fragmented datasets spread across credentialing systems, delegated entities, and third-party vendors. These datasets are often manually reconciled, inconsistently governed, and rarely updated in real time. The result is predictable: **inconsistent, outdated, and unreliable Provider information.**

The CMS-4208-F2 mandate, introduced by the Centers for Medicare & Medicaid Services, fundamentally changes this paradigm. It requires MA plans to supply accurate, structured provider directory data to CMS for integration into the Medicare Plan Finder (MPF) via the Health Plan Management System (HPMS).

This is more than a compliance requirement. It represents a shift toward making provider data a **real-time, consumer-facing asset**, one that directly influences how beneficiaries choose their health plans.

# The problem with the existing process

## Data decay and Inaccessible networks

At the core of this mandate is a long-standing issue: Provider directories that appear complete but fail in practice.

Provider data is highly dynamic. Physicians relocate or retire, practices open or close, affiliations change, and patient acceptance status fluctuates. Industry estimates suggest that **2%–3% of Provider data changes every month.** Without continuous updates, directories quickly become outdated.

This leads to several real-world consequences:



### Misleading plan selection:

Beneficiaries rely on inaccurate Provider counts



### Access barriers:

Patients struggle to find in-network providers due to outdated locations or incorrect status



### Declining member experience:

Poor access impacts satisfaction and quality scores



### Operational inefficiencies:

Increased call-center inquiries and grievance volumes

Most importantly, this undermines the concept of **network adequacy**. A network that looks robust on paper but is inaccessible in reality that fails its primary purpose.

CMS is stepping in because this gap between listed providers and actual access to care has become too large to ignore. Thus, considering MPF as the **primary digital front door** for Medicare beneficiaries, this mandate directly aims to push the accurate provider data to MPF via HPMS.

# Bridging MPF and HPMS

## From plan comparison to care access

MPF and HPMS have served different purposes. **MPF** is the primary "shopping" interface for Medicare beneficiaries. It helps beneficiaries to compare plans based on premiums, benefits, and ratings. While the **HPMS** serves as the regulatory system for MA plans to register, submit and maintain data endpoints.

CMS Regulatory mandate (4208-F2) connects these two systems in a meaningful way.

### Under this mandate:

MA plans submit Provider directory data through HPMS

CMS ingests, validates, and publishes this data into MPF

Verified Provider information is displayed within MPF where Beneficiaries can evaluate actual Provider access, not just plan benefits

This transforms MPF from a **cost comparison tool** into a "**network-aware**" **care access platform**.

For example, if CMS Plan Finder tool lists 300 cardiologists but a significant portion are no longer practicing, not accepting patients, or incorrectly listed, the beneficiary is making a decision based on flawed information.

By integrating validated Provider data into MPF, CMS ensures that plan selection reflects actual access to care, not just theoretical network size.

## What CMS mandate requires from MA Plans

The mandate introduces clear operational and technical responsibilities for MA organizations. The Federal regulations require Payers to maintain accurate, publicly accessible Provider directories, with clear expectations around data completeness, validation, and accountability. Building on this, CMS mandate (4208-F2) (finalized in September 2025) extends these requirements to Medicare Plan Finder for plan year 2027. The subsequent technical guidance released in November 2025 outlines how plans must structure, submit, and manage this data.

# Core requirements

## MA plans must:

Submit Provider directory data for all individual MA plans (HMO, PPO, MSA, PFFS)

Ensure the data is available to CMS in the required format and structure

Update Provider information within **30 days of any change**

Complete an **annual attestation** confirming that the data is accurate and complete

# The implementation timeline

CMS has outlined a structured roadmap to guide implementation.

Milestone Date	Event/Requirement
<b>Sept 18, 2025</b>	Publication of the MA Provider directory final rule (CMS-4208-F2).
<b>Feb 2, 2026</b>	API URL data entry fields become available in HPMS for plan management.
<b>May 4 – Aug 31, 2026</b>	<b>Critical Plan Testing Period:</b> Daily crawls and validation simulations by CMS.
<b>Sept 1, 2026</b>	<b>Deadline for CY 2027 Attestation:</b> Must be signed by CEO, CFO, or COO.
<b>Sept 18, 2026</b>	Target deadline for 10/1 production-ready CY 2027 data on API URLs.
<b>Oct 1, 2026</b>	Production release of the CY 2027 Medicare Plan Finder.

# The phased roadmap

CMS has defined a structured three-phase implementation strategy.

<p><b>Phase 1 (CY 2026): Interim Vendor Model</b></p>	<p>CMS uses third-party data sources (such as SunFire) while plans prepare their systems. Plans may optionally contribute data during this phase.</p>
<p><b>Phase 2 (CY 2027): Dual Submission Model</b></p>	<p>Plans must submit data using one of two approaches:</p> <ol style="list-style-type: none"> <li>1. Machine-readable JSON files</li> <li>2. FHIR-based JSON APIs</li> </ol> <p>CMS will Crawl API URLs daily, ingest the data, and run validation checks.</p>
<p><b>Phase 3 (Future Vision): National Provider Directory</b></p>	<p>CMS is advancing toward a centralized <b>National Directory of Healthcare Providers &amp; Services (NDH)</b>. This will serve as a <b>single source of truth</b> for provider data across the ecosystem. The key characteristics includes -</p> <ol style="list-style-type: none"> <li>1. Built on FHIR-based APIs</li> <li>2. Feeds MPF and other CMS systems</li> </ol>



# Technical implementation requirements




Plans must choose between two technical tracks for **Phase 2**:

<p><b>Option 1: Machine-Readable JSON</b></p> <ul style="list-style-type: none"> <li>· Publicly hosted JSON files</li> <li>: Includes Provider details, plan relationships, and location data</li> <li>: Requires an index file listing all data URLs</li> <li>· Must support version tracking (e.g., ETag, Last-Modified headers)</li> </ul> <p>This approach is considered transitional - expected to phase out</p>	<p><b>Option 2: FHIR API-Based Submission</b></p> <ul style="list-style-type: none"> <li>: Based on HL7® FHIR® R4 and PDex Plan-Net standards</li> <li>: Must be publicly accessible (no authentication barriers)</li> <li>· JSON format only</li> <li>·</li> <li><b>Key FHIR resources used -</b> <ul style="list-style-type: none"> <li>· Insurance Plan</li> <li>· Location</li> <li>· Organization (Network)</li> <li>· Organization (Facility)</li> <li>· Organization Affiliation</li> <li>· Practitioner</li> <li>· Practitioner Role</li> </ul> </li> <li>·</li> <li><b>Operational mechanics</b> <ul style="list-style-type: none"> <li>· CMS performs daily crawling for ingestion</li> <li>· Validation checks: <ul style="list-style-type: none"> <li>· API availability</li> <li>· Schema compliance</li> <li>· Plan coverage completeness</li> <li>· Update frequency (≤30 days)</li> </ul> </li> </ul> </li> </ul>
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## Compliance enforcement

### The risk of MPF suppression

**CMS has introduced a strong enforcement mechanism: MPF suppression. Plans may be suppressed if:**

-  Attestation is not completed
-  Data fails validation checks
-  Data quality issues exceed acceptable thresholds

This shifts compliance from a backend activity to a market-facing risk. It can impact MA plans with reduced Plans visibility, their providers may not appear in MPF or the Enrolment may be declined.

# Strategic recommendations for Payers

Compliance should not be treated as a check-the-box exercise. It is an opportunity to improve member experience and retention by fundamentally rethinking how Provider data is managed. To stay compliant and competitive, Payers should focus on the following priorities:

## 1. Build an integrated Provider data supply chain

Create a unified approach to Provider data by integrating credentialing, onboarding, and network systems. Focus on cleansing and normalizing data across sources and establish a single “golden record” for each Provider.

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## 2. Move beyond basic FHIR compliance

Many plans implemented FHIR APIs in response to earlier mandates since July 2021, but gaps remain like -data is often incomplete, updates are not timely, referential relationships between plans, networks, and providers are weak or missing. Payers should strengthen their interoperability layer by:

- Focusing on data quality orchestration, not just API exposure
  - Aligning with implementation guides (e.g., supporting required resources like Practitioner, PractitionerRole, Organization, Location, and InsurancePlan etc..)
  - Ensuring referential integrity, avoiding missing links between key resources
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## 3. Enable continuous validation and real-time readiness

With CMS expected to query APIs daily, so plans must move toward continuous data validation:

- Implement automated, API-first data verification workflows
- Monitor data freshness and accuracy in near real time
- Maintain and regularly update API endpoints

CMS requires a minimum 85% directory accuracy rate - covering locations, contact details, specialties, and network status - and gaps can lead to regulatory action, corrective measures, and potential enrolment freezes.

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## 4. Strengthen governance and future readiness

Payers should establish validation workflows and implement monitoring for data freshness and accuracy. Build systems that support -Scalable data exchange, Real-time updates and readiness for national directory integration and auditability

# Way forward

CMS has progressively pushed toward better provider data through public Provider directory mandates, network adequacy rules, and interoperability regulations mandating FHIR-based Provider Directory APIs (since 2020 Patient Access Rule) However, these efforts have often remained fragmented, exposing weaknesses in underlying provider data systems.

This regulatory mandate represents a turning point. It shifts Provider directory data from a static compliance requirement to a dynamic, consumer-facing asset by -

- Enabling the Medicare Plan Finder becoming a network-aware decision platform
- FHIR APIs evolving into the primary mechanism for data exchange
- The National Directory of Healthcare Providers & Services (NDH) emerging as a future single source of truth

Looking ahead, CMS is driving the industry toward a future where inaccurate directories are no longer acceptable. MA organizations that invest early in high-quality, real-time data capabilities will not only avoid compliance risks but also build trust with beneficiaries who depend on accurate Provider information when making care decisions.

## References

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