

File Formats and Submission Timeline

Q: For October 1, 2026, will CMS accept both machine-readable JSON and FHIR-based JSON files for MPF provider directories?

A: Yes, both formats will be accepted.

Q: When will CMS require FHIR-based JSON, phasing out the machine-readable JSON option?

A: Our intent is to transition fully to FHIR-based JSON for Contract Year (CY) 2028 at the earliest. CMS will not expect plans to switch over in the middle of the CY 2027 cycle.

Q: Is CMS planning to access provider directory data directly through plans' FHIR API endpoints, rather than through exported files?

A: There are no definitive plans at this time to access FHIR API endpoints directly. For CY 2027, CMS is asking plans to export FHIR-based JSON or machine-readable JSON files and post them to their contract-level MPF Provider Directory URL. This approach aligns with the "FHIR bulk publish" approach referenced in CMS guidance, rather than direct API access.

Key Dates

Q: What's the significance of September 18?

A: September 18, 2026 is CMS's target date for plans to have production-ready provider directory data available on their MPF provider directory URLs. This is also the deadline for completing the MPF Provider Directory attestation in HPMS.

Q: Does the ingestion and validation process stop on September 18?

A: No. Testing, the provider directory plan preview, and the daily ingestion and validation process all continue on an ongoing basis after that date. September 18 is a target checkpoint, not a cutoff.

Q: When does the new provider directory data go live on MPF?

A: The data is scheduled to go live on the CY 2027 MPF on October 1, 2026. CMS is considering taking a snapshot of data a day or two in advance of October 1 to establish a stable baseline for the initial launch. This approach is not yet finalized. If this is finalized CMS will communicate a specific date to plans in advance. Regardless, the routine daily ingestion process would resume as of October 1 and continue indefinitely.

Q: May plans continue to submit updates after September 18 and October 1 (when the MPF public preview launches)?

A: Yes. Because the provider directory is a living dataset that is always subject to change, neither date is a finish line. Plans are expected to keep adjusting — whether responding to actual provider or facility changes or to CMS validation findings — on an ongoing basis.

MPF Provider Directory Attestation

Q: Is the attestation a one-time event, or does the attestation need to be redone every time data changes?

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A: The provider directory attestation is a snapshot in time. CMS does not require plans to re-attest or recertify each time the underlying data changes. CMS' memo "Update to Contract Year 2027 Medicare Advantage Provider Directory Attestation Deadline" released on August 27, 2026 further clarifies the attestation requirement.

Q: Does the September 18 attestation need to reflect perfectly clean data?

A: No. The attestation reflects a plan's status — accurate, complete, and truthful — at the time it's made, not a certification of a flawless dataset. Considering this is the first year for this process, and given the scale of the data, CMS does not expect submissions to be fully cleared of errors. Please refer to the following passage of the August 27, 2026 attestation memo:

"CMS recognizes that MA organizations are implementing new processes and systems to make provider directory data available for use in Medicare Plan Finder (MPF), and that provider directory data may be affected by operational and data-source challenges, including dependencies on providers, delegated entities, vendors, and other third parties. As CMS and MA organizations continue to work collaboratively through this initial implementation period, CMS remains focused on supporting a successful transition to these new requirements."

For the CY 2027 provider directory attestation, CMS recognizes that MA organizations may continue to refine their processes for maintaining, validating, updating, and correcting provider directory data. CMS has not prescribed a specific methodology for these activities. In completing the CY 2027 attestation, MA organizations should rely on their documented processes and reasonable, good-faith efforts to maintain accurate provider directory data. MA organizations remain responsible for updating information subject to § 422.111(m) within 30 days of the date the MA organization becomes aware of a change."

Q: If a plan has open validation errors, can the plan still complete the attestation and keep working through issues afterward?

A: Yes. There is no expectation that the provider directory data will be "locked down" once the attestation is complete. Following attestation, plans can continue to update and make all allowed and required changes to its directory data.

Q: If a plan has unresolved Level 2 (record-skip) errors by September 18, does that block the attestation?

A: No. While these records will be suppressed on MPF until resolved, the rest of the plan's dataset will not be affected. These errors will not prevent plans from completing the attestation by September 18, 2026.

Q: Once CMS provides clarification on a record that was pending review, is the plan expected to update its data?

A: Yes. Once CMS gives clarification on a flagged record, the plan is expected to make the corresponding update in its source data going forward.

Error Tiers and Validation Process

Q: What are the different error tiers?

A: There are three tiers of validation findings:

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- **Level 1 – Fatal:** The dataset cannot be processed at all.
- **Level 2 – Record Skip:** CMS has identified an issue with a specific record. The affected record will not be shown on MPF until the issue is resolved, but the rest of the file will be shown.
- **Level 3 – Informational Warning:** No action is required unless the plan determines the flagged item reflects a genuine issue. CMS clarified this language in the September 4, 2026 version of the technical guide. Level 3 findings do not require a fix by default.

Q: How often are plan files downloaded and validated once submitted?

A: CMS downloads, ingests, and validates provider directory data daily around 4:00 a.m. ET. This process is ongoing.

Q: Are there file size or volume limits for submissions?

A: Yes. There is a maximum of 10,000 individual files permitted per contract number. This is a file count limit, not a record count limit. Moreover, each file cannot exceed 300 MB. There is no limit on the number of NPIs within a single JSON file, and a single-line JSON string with no line breaks is fine.

Q: How quickly must plans correct errors or update provider information after a change?

A: Plans are expected to correct errors or update data as soon as possible. For data changes, plans are required by regulation to update their provider directory within 30 days of being notified about the change. However, plans must correct Level 1 validation errors immediately as this type of error prevents CMS from processing the provider directory data.

Q: How can plans retrieve validation reports programmatically instead of downloading manually?

A: HPMS offers an API option for retrieving daily validation files. On the publicly available HPMS landing page – <https://hpms.cms.gov> – go to the "Documentation" resource and access the HPMS Plan API Documentation link.

Q: If a plan stops seeing a validation error file after previously receiving one, does that mean there are no more errors?

A: CMS intends to issue a blank validation file to represent a clean (no findings) submission, but that release has not yet occurred. In the interim, plans should contact the HPMS Help Desk at either hpms@cms.hhs.gov or 1-800-220-2028 for assistance.

Q: Is there a comprehensive list of validation error codes with causes and remediation steps?

A: [Appendix E of the technical guide](#) lists the Level 1, 2, and 3 validation levels, including the individual errors/findings and suggested plan actions to remediate the issue.

Q: Is there a sandbox environment where vendors (not just payers) could test FHIR files before deploying them to payers?

A: A provider directory sandbox environment is not available, but is under consideration for a future release.

Provider Directory Plan Preview

Q: What's the purpose of the Provider Directory preview in HPMS, and does it show exactly what will appear on Medicare Plan Finder?

A: CMS has modeled the provider directory plan preview on the existing Part D drug pricing preview. The goal is to confirm that a plan's directory data is being returned via search as expected, not to preview the exact consumer-facing display. Plans are not expected to review every provider and facility record. Rather, it should be used to execute targeted, sample-based verification while building and testing provider directory data.

Q: How does the preview differ from the live Medicare Plan Finder search?

A: Plans can only preview their own data in the preview, whereas the MPF search reflects the full universe of plan data.

Q: Is the preview a temporary tool, or will it stay available?

A: The plan preview will remain operational in HPMS throughout the year.

Q: What fields currently show in the preview, and will more be added?

A: The preview includes the following fields that reflect MPF's October 1 launch: first name, last name, credentials, specialty, and address. CMS intends to introduce additional fields over time.

Q: What should a plan do if something looks off in the preview?

A: We recommend that you check your submitted data to verify that it meets the technical specifications. If it does, then submit a comment through the survey link, which is provided both in the [HPMS provider directory plan preview memo](#) and within the preview module itself.

Q: Are pharmacy NPIs part of this provider directory submission?

A: No. CMS collects pharmacy networks for MPF through a separate process using the Part D Pricing File Submission (PDPFS) module in HPMS. If desired, plans can strip out the pharmacy records for MPF purposes. Alternatively, CMS has implemented a process to suppress submitted pharmacy records from both MPF and the provider directory plan preview.

Q: Is there a sample or example for the index.json file, and where can it be found?

A: Sample code for the index.json file is included in the technical guide's "Hosting Requirements for Machine-Readable and FHIR-Based JSON" section. This section provides a machine-readable JSON example and a FHIR-based JSON example. If these examples are not sufficient, plans should contact CMS for more information.

Q: Can the index.json file be hosted as a static file in a public-facing storage service (like an S3 bucket), rather than through a dynamic API endpoint?

A: Yes. This approach is acceptable, and many plans are already doing it.

Q: Why does an NPI appear in the plan preview when the NPI was not included on the plan's provider directory?

A: If the NPI is valid, the preview will display the NPI itself even if not supplied by the plan in their directory data. In this scenario, the preview will indicate that the NPI is not covered for the selected plan.

Data Sourcing and Cross-Checks with NPPES

Q: If provider data from vendors is missing specialty/taxonomy descriptions, is it acceptable to populate the field using NPI-based lookups from NPPES and NUCC taxonomy descriptions?

A: Yes. This approach is acceptable.

Q: Will CMS notify plans directly when NPPES data is used to populate a field on Medicare Plan Finder in place of what a plan submitted?

A: While CMS will not provide a direct notification, plans can use their validation reports to flag cases where this would occur.

Q: How is CMS using NPPES for validation purposes?

A: CMS is using NPPES to validate the NPI number, NPI name, and provider type in the MPF provider directory data. NPPES is **not** used to validate addresses.

Q: How is CMS validating addresses?

A: CMS uses Smarty (formerly known as Smartystreets) to validate addresses in the MPF provider directory data. NPPES is **not** used in any way for address validation. If an address cannot be geolocated in Smarty, the record will be flagged as a Level 2 record skip finding.

File Hosting and Crawler Behavior

Q: What may cause intermittent connectivity errors (for example, repeated 429 or 500 errors) during file crawls, even when there are no changes to source data or configuration?

A: A 429 error generally means the plan's content delivery network (CDN) or server rate-limiting is triggered, while a 500 error is produced when the plan's server fails to respond. Where possible, CMS has tuned its crawler to avoid triggering these protections so plans should reach out to their hosting vendor.

Program Requirements

Q: How are the MPF Provider Directory Rule and the Interoperability/Patient Access Rule related — are they the same requirement?

A: No. They represent two distinct requirements. The May 2020 *Interoperability and Patient Access Final Rule* (CMS-9115-F) requires MA organizations and other payers to maintain a FHIR API for their provider directory. On September 18, 2025, CMS published *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 Second Final Rule* (CMS-4208-F2). This rule finalized requirements at § 422.111(m) for MA organizations to supply their MA provider directory data to CMS/HHS for publication online on MPF. To meet the MPF requirement, CMS is requiring MA plans to export and post their provider directory files to a contract-level MPF provider directory URL. The MPF-specific effort is the focus of these Office Hours sessions. MA organizations must comply with both sets of requirements.

Q: Are delegated or supplemental benefit providers (for example, meal delivery, in-home services, or transportation providers) required to be included in Plan Finder scope?

A: They should be included when the delegated or supplemental benefit provider meets the definition of provider at 42 CFR § 422.2 below:

“Provider means—

(1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and

(2) Any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.”

Q: How do we report telehealth providers?

A: While the provider directory requirements call for including telehealth providers, CMS’ current technical specifications do not support it for MPF purposes. CMS plans to update the specifications in a future release so that plans can report them to MPF at that time.

FHIR Data Element and Resource Guidance

Q. For MPF, should plans use *OrganizationAffiliation.organization*, *ParticipatingOrganization*, or both to represent facility locations in FHIR?

A: The technical guide expects location to be on *OrganizationAffiliation.organization*, not *participatingOrganization*. In cases where location appears on both *OrganizationAffiliation.organization* and *participatingOrganization*, plans will encounter difficulties during the processing of your directory data. We have identified two approaches that can be used to adjust to this CY 2027 specification:

- Delete *OrganizationAffiliation.organization* and CMS will fall back to *participatingOrganization*, OR
- Change the *participatingOrganization* location reference to be referenced on *OrganizationAffiliation.organization*

While it is CMS’ intent is to be consistent with the PDex, there is not sufficient time to make this type of change for CY 2027. CMS will actively seek input from plans to determine the CY 2028 technical specification changes that may be needed to accomplish that parity and reduce the effort it takes to prepare your FHIR data structures for MPF.

Q: Are elements marked "required" in the technical guide (for example, a practitioner's specialty on a practitioner role resource) mandatory for CMS to process the resource, even if Appendix E doesn't show a record-skip error for it?

A: Yes. If an element is indicated as required in the guide, the expectation is that it will be present.

Q: For the optional field “language,” can a plan submit a FHIR "null flavor" instead of a value?

A: Language should be populated on every record. If English applies, the value "English" must be submitted.

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Q: Do plans need to include an actual network organization resource for network references to work?

A: No. CMS does not need the network organization resource itself. The matching is done using the ID. Specifically, the system queries the insurance plan resource for the network reference, then matches that ID to the corresponding reference on the organization affiliation or practitioner role resources.

Q: In the FHIR UML diagrams, organization affiliation links organizations to networks. If an organization has no relationship with another organization, is it expected to have an affiliation resource anyway?

A: No. CMS' primary use case for organization affiliation is linking a facility to an organization through the organization reference. Additional organization resources that are not facilities (for example, the insurance company or the network itself) will be ignored if included. CMS' preference is to omit those non-facility organization resources and submit only facilities and the organization affiliations tied to them, if feasible.

Q: Does CMS have a preferred FHIR representation for medical group or hospital affiliations (for example, through practitioner role or organization affiliation)?

A: Currently, CMS is not collecting the practitioner role's organization reference for this purpose. At this time, provider groups/affiliation groupings will not be included on MPF.

Q: How does CMS match a location to a facility's NPI?

A: For facilities, locations are referenced through organization affiliation, which links back to an organization. For individual providers, practitioner role references a location and also references back to the practitioner.

Q: How should plans handle NPIs for provider groups or facilities, especially when there's no separate NPI Type 2 available (for example, when an individual owner's NPI Type 1 is also used for the group)?

A: Group-level NPIs should not be included per the current technical specifications.

Q: What does a complete, correctly formatted unique MA identifier (plan ID) look like?

A: The format provided in the technical guide is accurate:

[CMS Contract Number]-[CMS Plan ID]-[CMS Segment ID]

000 must be used to denote a plan that is not segmented.

Example: H9999-001-000

These identifiers are created during the annual plan bidding process. The plan bidding, plan benefit package, and/or marketing teams at the MA organization will have these identifiers.