

Supporting Statement A  
Provider Directory Data for Medicare Plan Finder  
CMS-10906, OMB 0938-TBD

## **Background**

Consistent with our September 19, 2025 final rule, this 60-day collection of information request is associated with amendments to the disclosure requirements under 42 CFR 422.111 for the Medicare Advantage (MA) (that is, Part C) program. The amendment will increase beneficiaries' access to MA organizations' provider data in the CMS Medicare Plan Finder (MPF) tool, which will contribute to the beneficiaries' ability to make more informed decisions about their health care.

MPF is an online tool that helps Medicare beneficiaries compare and shop for MA and Part D plans. However, prior to the September 2025 rulemaking, MPF did not include information on MA organizations contracted provider networks.

For plan years beginning on or after January 1, 2026, the final rule requires that MA organizations must:

- (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 § 422.111(m) is accurate.

These changes are intended to promote informed beneficiary choice and transparency found in online resources, empowering people with Medicare to make informed choices about their coverage.

CMS will publish a technical specification guide that will provide operational instructions for MA organizations to meet the new requirements. The guide will include the attestation language and will exist independently of this collection of information request.

Overall, this iteration would add 700 respondents/responses and 6,300 hours at a cost of \$735,070.

This collection of information request does not include any reporting instruments. Reporting instructions are set out in the September 19, 2025 final rule and are codified in the CFR.

## **A. Justification**

### **1. Need and Legal Basis**

Based on current statutory and regulatory authority, CMS has implemented MPF, an online tool where current and prospective beneficiaries can explore their Medicare coverage options. On MPF, individuals can shop for Medicare coverage options and make choices based on a variety of search criteria, such as plan benefits, premiums, deductibles, and star ratings. Prior to the implementation of the September 2025 final rule, however, MPF has not included search capability or information on MA organizations' contracted provider networks.

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.

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, MA plan 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 is expanding 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.

The combined intent of these requirements is to allow CMS's MPF to access the MA organization's provider directory data, so that CMS may integrate this data within MPF. CMS has also previously adopted regulations to implement requirements applicable to MA organizations for publicly accessible, accurate, and timely provider directory information through the May 1 2020 (85 FR 25510) Interoperability and Patient Access final rule (CMS-9115-F, RIN 0938-AT79). The provider directory requirements of that 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. The requirements are codified in § 422.120(a) - (c) and § 422.504(a)(18).

## 2. Information Users

MA organizations will make their provider directory data available to CMS in the required format and maintain the data, as required, on an ongoing basis. This use has been captured in section 12 of this Supporting Statement as a one-time instance of 8 hours of computer programmer work.

CMS will present the provider directory information publicly, including, but not limited to, for the use of the names of current health care providers as search criteria as a tool to find a Medicare insurance plan that contracts with those providers.

### 3. Use of Information Technology

MA organizations will submit or otherwise make their plan provider directory data available to CMS/HHS in a format, manner, and timeframe determined by CMS/HHS (as specified by CMS through the technical specifications) for publication online within MPF. MPF users will use the data, including, but not limited to, the names of their current doctors, as search criteria when using MPF to shop for and compare MA plans. MPF users will access MPF via the internet.

An officer of each MA organization will 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 § 422.111(m) is accurate.

### 4. Duplication of Efforts

While this information collection is similar in scope to an operational policy overseen by the Center for Consumer Information & Insurance Oversight (CCIIO), there is no overlap between the two policies.

### 5. Small Businesses

This information collection does not impact small businesses or other small entities. The information collection only applies to Medicare Advantage insurance plans.

### 6. Less Frequent Collection

To be responsive to the needs of MPF users, the systems that operate MPF will automatically retrieve the available data on an ongoing basis to effectuate the use of the data to assist MPF users in finding a MA plan that best suits their needs with regards to network providers.

### 7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are

- consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secrets, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

#### 8. Federal Register/Outside Consultation

The provider directory/Medicare Plan Finder (MPF) provisions were proposed in our December 10, 2024 (89 FR 99340) proposed rule (CMS-4208-P, RIN 0938-AV40). While the proposed provisions were not finalized in our subsequent April 2025 (90 FR 15792) final rule (CMS-4208-F1, RIN 0938-AV40), the provisions were finalized in our September 19, 2025 (90 FR 45140) final rule (CMS-4208-F2, RIN 0938-AV40).

This 60-day collection of information request is associated with the provisions that were finalized in our September 19, 2025 (90 FR 45140) final rule (CMS-4208-F2, RIN 0938-AV40). This iteration requests OMB's approval of the finalized requirements using the standard non-rule PRA process which consists of the publication of 60- and 30-day Federal Register notices.

The 60-day notice published in the Federal Register on November 24, 2025 (90 FR 52956). Comments are due on/by November 24, 2026.

#### 9. Payments/Gifts to Respondents

There are no payments/gifts to respondents.

#### 10. Confidentiality

The information being collected is public information. There is no need or desire for confidentiality in this information collection.

#### 11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

#### 12. Burden Estimates

##### *Wage Estimates*

To derive average costs, the U.S. Bureau of Labor Statistics' (BLS') May 2024 National Occupational Employment and Wage Estimates for all salary estimates ([http://www.bls.gov/oes/2024/may/oes\\_nat.htm](http://www.bls.gov/oes/2024/may/oes_nat.htm)) provided data. In this regard, the following table presents BLS' mean hourly wage, the estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and the adjusted hourly wage.

#### National Occupational Employment and Wage Estimates

Occupation 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
MA organization chief officer	11-1011	126.41	126.41	252.82

As indicated, CMS is adjusting the employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because 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. Nonetheless, doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

#### *Collection of Information Requirements and Associated Burden Estimates*

*Initial Computer System Formatting Requirement* The reporting of provider directory data and updated directory data by MA organizations to CMS is ongoing, but it is part of an automated process. Each plan will create the necessary functionality within their system. This is a one-time burden for a computer programmer for each plan to create the functionality within their systems. CMS estimates that for each plan a computer programmer would spend 8 hours at \$99.66/hr.

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).

*Annual Chief Officer Attestation Requirement* The 700 plans include local and regional Coordinated Care Plans (CCP), Medicare Savings Account (MSA) plans, and Private Fee For Service (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 regulatory change is not relevant to Cost plans.

To operationalize the Format Provider Directories for Medicare Plan Finder provision at § 422.111(m), CMS finalized an applicability date of January 1, 2026, for this provision. CMS anticipates the need for technical support in conjunction with the release of the functionality specifications, and later testing, which the agency estimates to take place soon after the applicability date. However, CMS notes the January 1, 2026, applicability date does not refer to the date that the provider directory data supplied by MA organizations under this rule will be available on MPF for use by the public.

Regarding the attestation of the accuracy of the data provided by plans for use on MPF, CMS anticipates the ongoing labor burden of the attestation will be an annual burden of one hour on the part of an officer of the MA organization. In aggregate, CMS estimates an annual burden of

700 hours (700 plans \* 1/hr/plan) at a cost of \$176,974 (700 hr \* \$252.82/hr).

### *Burden Summary*

Regulation Under Title 42 of the CER	Respondents	Responses (per respondent)	Total Responses	Time per Response	Total Annual Time (hr)	Labor Rate (\$/hr)	Total Cost (\$)
Initial Computer System Formatting Requirement							
422.111(m)	700	1	700	8 hr	5,600	99.66	558,096
Annual Chief Officer Attestation Requirement							
422.111(m)	700	1	700	1 hr	700	252.82	176,974
TOTAL	700	2	1,400	varies	6,300	varies	735,070

### *Information Collection Instruments and Instruction/Guidance Documents*

CMS will publish a technical specification guide that will provide operational instructions for MA organizations to meet the new requirements. The guide will include the attestation language and will exist independently of this collection of information request.

#### 13. Capital Costs

There are no anticipated capital, start-up, and/or operational costs resulting from the collection of this information.

#### 14. Cost to the Federal Government

The estimated annual cost to the Federal Government is not a part of this package as it is part of the maintenance cost of MPF.

#### 15. Program/Burden Changes

Not applicable. There are no changes since this is a new collection of information request.

#### 16. Publication and Tabulation Dates

In accordance with the authority at section 1856(b) of the Act to establish standards for the MA program, and the provider directory requirements at section 1852(c)(1)(C) of the Act and § 422.111(b)(3), as well as the authority granted in section 1851(d) of the Act, CMS will require, under a newly established 422.111(m): (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. Updates to the provider directory data

made available to CMS follow the current requirement that MA organizations must update their provider directories no later than 30 days after being notified of a change in provider information.

17. Expiration Date

The expiration date will be displayed.

18. Certification Statement

No exception to item 19 on OMB Form 83-I is requested.

**B. Collection of Information Employing Statistical Methods**

No formal data collection employing statistical methods will be done. CMS may conduct statistical analysis of the data after it is entered into the system as needed for research purposes.