CMS Worksheet S-12

Requirements, Development, and Legal Authority

Prepared by Strategic Health Care, July 2026

Overview. CMS has added Worksheet S-12 to the Medicare hospital cost report, Form CMS-2552-10. The worksheet collects weighted median Medicare Advantage Organization (MAO) payer-specific negotiated charge data by Medicare Severity Diagnosis Related Group (MS-DRG).

At-a-Glance Summary

Item	Summary
Worksheet name	Worksheet S-12 - Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data.
Cost report form	Supplemental worksheet to Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report.
Effective date	Cost reporting periods ending on or after January 1, 2026.
Who reports	Subsection (d) IPPS hospitals and subsection (d) Puerto Rico hospitals, unless exempt.
What is reported	The weighted median MAO payer-specific negotiated charge for each MS-DRG with inpatient discharges during the cost reporting period.
Primary data sources	The hospital's most recent hospital price transparency machine-readable file (MRF) as of the cost report filing date, and inpatient discharge data for the cost reporting period.
Key exclusions	Capitated payer-specific negotiated charges and inpatient discharges paid on a capitated basis are excluded.
Future CMS use	CMS finalized use of the collected data in a market-based MS-DRG relative weight methodology beginning with FY 2029 relative weights.

1. CMS Worksheet S-12: Requirements

What the form is

Worksheet S-12 is a supplemental cost-report worksheet titled "Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data." It is designed to collect MAO negotiated-charge data by MS-DRG from affected hospitals.

OMB/PRA status. The S-12 collection is identified as CMS-10935 with OMB Control No. 0938-1486. OIRA approved the collection on January 22, 2026, and the OMB expiration date shown in the CMS instructions is January 31, 2029.

Who must complete S-12

Covered hospitals. For cost reporting periods ending on or after January 1, 2026, subsection (d) hospitals and subsection (d) Puerto Rico hospitals must report the weighted median of the payer-specific negotiated charges negotiated with each MAO for each MS-DRG.

Exempt hospitals. CMS identifies two categories of hospitals exempted from completing Worksheet S-12:

- Hospitals that do not negotiate payment rates and only receive non-negotiated payments, such as certain Indian Health Program hospitals and federally owned and operated facilities.
- Hospitals paid under the Maryland Total Cost of Care Model during the model's performance period.

What data must be reported

Reportable measure. For each MS-DRG with inpatient discharges during the cost reporting period, the hospital must report the weighted median MAO payer-specific negotiated charge.

Worksheet lines. The worksheet runs from line 1 through line 997, corresponding to MS-DRG reporting lines. For each applicable line, the hospital reports the weighted median charge for that MS-DRG.

Definition of weighted median. CMS defines the weighted median MAO payer-specific negotiated charge as the weighted median of MAO payer-specific negotiated charges, weighted by the number of inpatient discharges for those payers that occurred during the cost reporting period.

Data sources hospitals must use

- Most recent MRF: The hospital's most recent hospital price transparency machine-readable file as of the cost report filing date. This is the MRF made public under 45 CFR 180.40(a).
- MAO negotiated charges in the MRF: The payer-specific negotiated charges for inpatient items and services made public under 45 CFR 180.50(b)(2)(ii).
- Inpatient discharge data: The hospital must count inpatient discharges by MAO and MS-DRG for the cost reporting period.

Calculation requirements

1. Identify each MAO payer-specific negotiated charge from the hospital's most recent MRF as of the cost report filing date. If the charge is expressed as a percentage or algorithm, substitute the dollar amount required in the MRF. Exclude payer-specific negotiated charges that represent capitated payment.
2. For the cost reporting period, sum inpatient discharges for each MAO for each MS-DRG. Exclude discharges where the hospital received payment on a capitated basis.
3. For each MS-DRG, list each MAO payer-specific negotiated charge once for each inpatient discharge for that MAO during the cost reporting period.
4. Order the list from lowest to highest and compute the median. If the list has an odd number of values, use the middle value. If it has an even number of values, use the mean of the two middle values.

Non-MS-DRG contract methodologies

Crosswalk/classification requirement. Hospitals that negotiate MAO payer-specific charges using a non-MS-DRG system must crosswalk those codes, or classify those discharges, to MS-DRGs. CMS states that hospitals may use the CMS Grouper and associated definitions manual to support the crosswalk or classification.

Practical compliance implications

- Confirm whether the hospital is subject to S-12 or falls within one of the CMS exemptions.
- Validate that the hospital's most recent MRF contains MAO negotiated charges in a usable format, including dollar values for percentage- or algorithm-based arrangements.
- Reconcile MAO contract data, price transparency MRF data, inpatient claims/discharge data, and MS-DRG groupings.
- Exclude capitated charges and capitated discharges consistently.
- Document the methodology, data sources, crosswalks, exclusions, and median calculations for audit support.

> ***Primary source for Section 1: CMS Provider Reimbursement Manual, Part 2, Chapter 40, Form CMS-2552-10, Section 4012.50, Worksheet S-12 instructions; and RegInfo.gov ICR package for CMS-10935 / OMB Control No. 0938-1486.***

2. How S-12 Was Developed and Under What Authority

Development history

Initial concept in FY 2021 IPPS rulemaking. CMS initially adopted a market-based data collection concept in the FY 2021 IPPS/LTCH PPS final rule. That policy would have required hospitals to report median payer-specific negotiated charge data by MS-DRG on the Medicare cost report, with the goal of using the data for a market-based MS-DRG relative weight methodology.

Repeal in FY 2022 IPPS rulemaking. CMS later repealed that prior policy in the FY 2022 IPPS/LTCH PPS final rule, while indicating it would continue to evaluate whether market-based data were appropriate for rate-setting.

Revival and finalization in CY 2026 OPPS/ASC rulemaking. CMS revived the concept in the CY 2026 OPPS/ASC rulemaking, with modifications. The finalized policy collects MAO payer-specific negotiated charge data from hospital MRFs and hospital inpatient discharge data, requires reporting by MS-DRG, and applies for cost reporting periods ending on or after January 1, 2026.

Operational implementation. CMS implemented the requirement through the Medicare cost report by adding Worksheet S-12 to Form CMS-2552-10. The collection was processed under the Paperwork Reduction Act as CMS-10935, OMB Control No. 0938-1486.

CMS's stated policy purpose

CMS states that collecting MAO negotiated-charge data supports price transparency and a market-based approach to Medicare fee-for-service payment. CMS finalized use of the data in a market-based MS-DRG relative weight methodology beginning with FY 2029 relative weights, while indicating it may consider refinements through future rulemaking before the FY 2029 implementation.

Legal authority CMS relies on

Cost-reporting authority. CMS relies on Medicare cost-reporting statutes and regulations that require participating providers to furnish information needed to determine Medicare payment and to support program

administration. These include Social Security Act sections 1815(a), 1833(e), and 1861(v)(1)(A), along with cost-reporting regulations at 42 CFR 413.20 and 42 CFR 413.24.

IPPS MS-DRG authority. CMS also relies on Social Security Act section 1886(d)(4), which authorizes the Secretary to establish DRG classifications, assign weighting factors reflecting relative hospital resources used, and adjust those weights over time. CMS's position is that MAO negotiated rates can serve as market-based evidence relevant to relative resources across MS-DRGs.

Hospital price transparency authority. The MRF data source comes from the hospital price transparency rules, which require hospitals to make public standard charge information, including payer-specific negotiated charges. CMS's hospital price transparency framework is codified at 45 CFR Part 180.

Paperwork Reduction Act authority. Because S-12 is an information collection, CMS submitted the collection to OMB/OIRA. The approved information collection is CMS-10935, "Weighted Median MAO Payer-Specific Negotiated Charge Data Form," under OMB Control No. 0938-1486.

Legal and policy controversy

Hospital and stakeholder objections. Commenters opposed the policy and questioned whether CMS could use MAO negotiated rates to set or recalibrate Medicare IPPS MS-DRG relative weights. A central objection was that section 1886(d)(4) focuses on relative hospital resources used, while payer-negotiated rates may reflect bargaining power, market leverage, network dynamics, benefit design, and other non-resource factors.

CMS response. CMS rejected those objections. CMS took the view that negotiated MAO rates still reflect, at least in part, the resources required to furnish hospital services, and that the agency's cost-reporting and IPPS authorities permit collection and future use of the data for a market-based relative weight methodology.

Practical significance. The policy is significant because it links three systems that hospitals often manage separately: the Medicare cost report, the hospital price transparency MRF, and inpatient MAO contract/payment data. Hospitals will need a defensible internal process for reconciling those systems and preserving workpapers supporting the reported weighted medians.

Bottom line

S-12 was developed as a regulatory and cost-reporting mechanism, not through a new statute specifically naming "S-12." CMS's authority theory is that cost-reporting rules allow it to collect the data; IPPS DRG-weight authority allows it to use the data to inform relative weights; and hospital price transparency rules supply the underlying negotiated-charge data source.

> ***Primary source for Section 2: CY 2026 OPPS/ASC Final Rule with Comment Period (CMS-1834-FC), CMS fact sheet, and RegInfo.gov OIRA information collection package for CMS-10935 / OMB Control No. 0938-1486.***

Source References

1. CMS Provider Reimbursement Manual, Part 2, Chapter 40, Form CMS-2552-10, Transmittal 25, including Worksheet S-12 instructions, Section 4012.50: https://www.cms.gov/files/document/r25p240i.pdf
2. CY 2026 OPPS/ASC Final Rule with Comment Period, CMS-1834-FC, Federal Register/public inspection PDF, FR Doc. 2025-20907: https://public-inspection.federalregister.gov/2025-20907.pdf

3. CMS Fact Sheet: Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule (CMS-1834-FC): https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center
4. RegInfo.gov/OIRA ICR Package: Supplemental to Form CMS-2552-10: Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data (CMS-10935), OMB Control No. 0938-1486: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202512-0938-006