New MA Cost Report Requirements

What Hospitals Need to Know

May 5, 2026

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Agenda

1. Introductions
2. Cost Report Update
3. Price Transparency Updates and Related Contract Negotiations
4. Price Transparency for MAO Cost Report

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Learning Objectives

Provide an update on reimbursement regulations and impacts on cost reporting

Explore new price transparency requirements effective January 2026 and how they affect contract negotiations

Discuss new Medicare Advantage (MA) cost report requirements effective January 2026 and how to leverage data from the price transparency machine-readable file (MRF)

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Introductions

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Cost Report Update

Cost Report Changes for 2026

Summary

- Effective for cost reporting periods ending on or after January 1, 2026
- New reporting requirement: Median MA negotiated rates by MS-DRG
- Reported on Worksheet S-12
- Data supports MS-DRG weights beginning FY 2029

History

- Nearly identical to the mandate in the FY 2021 IPPS final rule
- Originally for cost reports with years ending January 2021.
- Ultimately delayed and rescinded in the FY 2022 IPPS final rule

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Policy Intent

Introduces MA payment data into Medicare rate setting (MA contracting patterns feed future Medicare rates).

IPPS remains budget-neutral.

Payment redistribution across MS-DRGs is likely over time.

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Who Must Report

Required to Report

General acute care hospitals subject to IPPS ("subsection (d) hospitals") for cost reporting periods ending on or after January 1, 2026 (cost report due dates of June 30, 2026 and after)

Not Required to Report

Critical access hospitals, rural emergency hospitals, or other hospitals that only receive non-negotiated payments, *e.g.*, Indian Health Service hospitals, Maryland Total Cost of Care Model providers

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What Is Reported and Where?

What

- Median MA Payor-Specific Negotiated Charge
- Calculated by MS-DRG
- Source Data: Price Transparency MRF

Where

- New Worksheet (Supplement to CMS-2552-10)
- Implemented via CMS Transmittal 25

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Cost Report Worksheet

DRAFT SUPPLEMENTAL TO FORM CMS-2552-10

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED
OMB NO. XXXX-XXXX
EXPIRES MM-DD-YYYY

WEIGHTED MEDIAN MEDICARE ADVANTAGE ORGANIZATION PAYER - SPECIFIC NEGOTIATED CHARGE DATA	PROVIDER CCN: ______	PERIOD: FROM: ______ TO: ______

	MS-DRG	MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) TITLE	CHARGE	
1	001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC		1
2	002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC		2
3	003	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITH MAJOR O.R. PROCEDURES		3
4	004	TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITHOUT MAJOR O.R. PROCEDURES		4
5	005	LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT		5
6	006	LIVER TRANSPLANT WITHOUT MCC		6
7	007	LUNG TRANSPLANT		7
8	008	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT		8
9	009	RESERVED FOR FUTURE USE		9
10	010	PANCREAS TRANSPLANT		10
11	011	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH MCC		11
12	012	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH CC		12
13	013	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITHOUT CC/MCC		13
14	014	ALLOGENEIC BONE MARROW TRANSPLANT		14
15	015	RESERVED FOR FUTURE USE		15
16	016	AUTOLOGOUS BONE MARROW TRANSPLANT WITH CC/MCC		16
17	017	AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC		17
18	018	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHERAPIES		18
19	019	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS		19
20	020	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH MCC		20
21	021	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH CC		21
22	022	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITHOUT CC/MCC		22
23	023	CRANIOTOMY W/ MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS W/ MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W/ NEUROSTIMULATOR		23
24	024	CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS WITHOUT MCC		24
25	025	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH MCC		25
26	026	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH CC		26

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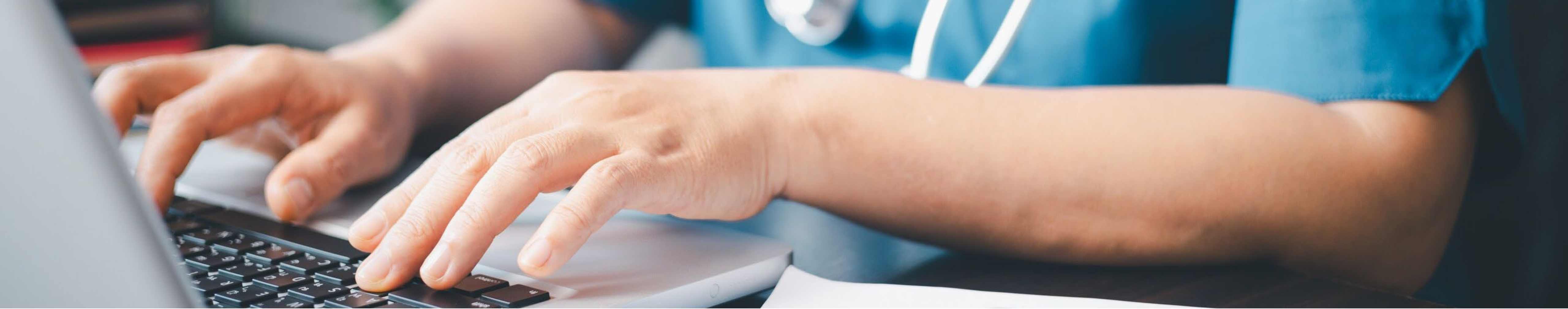
Preparation and Documentation Considerations



Confirm applicability and get organized!

Validate the MRF

Perform dry run calculations for reasonableness

Confirm alignment between the MRF, cost report, and claims data

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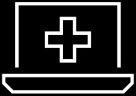
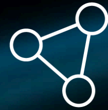
Key Takeaways



Understand the risk of unsupported and incorrect data

- Audit implications
- Future DRG Impacts



Will require cross-functional coordination within the organization

This is complex! Start now!

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Price Transparency Updates and Related Contract Negotiations

What Is Price Transparency Data?

Three regulatory branches require different stakeholders to publish pricing information.

Most Complete

Payor Transparency

Transparency in Coverage (TiC) requires commercial insurers to post all negotiated rates for every medical billing code. This covers every provider from the largest health systems to the smallest practices.

Hospital Transparency

Hospitals must post contracted rates for commercial, Medicare, and Medicaid across all billing codes. This includes median allowed amounts, 10th/90th percentiles, and claim counts.

Drug/Rx Transparency

Commercial payors will be required to post drug pricing data. This requirement has been postponed twice. The timeline is currently TBD per the latest CMS proposed rules.

Source: Payerset

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Payor Data: Where We Are and Where We're Going

Payerset works directly with CMS to advise on the next requirements for insurers and monitor compliance.

Current Challenges

- 14T+ rows of payor pricing data & growing
- 10,000+ files per payor, some over 100K files
- Massive redundancy, same rates duplicated across plans
- Expiring file links, download before they disappear
- Rate limiting & hidden files, payors make access difficult

What's Changing

Schema 2.0 (February 2026)
Network names, business names, issuer names, inpatient/outpatient setting codes

Proposed: Network-Based Files
One file per network (not per plan), eliminating massive redundancy

Proposed: Utilization File
Annual file showing which providers actually received reimbursement

Proposed: Quarterly Updates
Moving from monthly to quarterly refresh cadence

The Journey

Source: Payerset

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Hospital Price Transparency

Requirements place a significant burden on organizations whose focus is delivering care.

What Hospitals Must Publish

- **Include all Type 2 Organizational NPIs that start with 27 or 28 taxonomy: 27 – Hospital Units (Psych, Rehab, Epilepsy); 28 – Hospitals (LTC, General Acute, CAH, etc.)**
- Contracted rates for all payors (commercial, Medicare, Medicaid)
- All medical billing codes and Rx/drug codes
- **Median, 10th, and 90th percentile total allowed amounts (12- to 15-month window)**
- **Claim (835 remit) counts for transparency and trust**
- Payor-specific negotiated charges (including % of charge and algorithm-based)
- **Attestation language on MRF accuracy**
- Shoppable services file for the top 300 procedures

The Leapfrog Pattern

CMS tests new transparency requirements on hospitals first. Once the edges are smoothed and compliance is established, those rules migrate to payor transparency, and vice versa.

Implementation Burden

New systems and better data: Many hospitals are investing in new infrastructure to meet evolving requirements.

Complex calculations: Median allowed amounts, percentiles, and deriving rates from % of charge contracts are confusing to implement.

Long-term vision: Hospital and payor transparency data will reconcile, but this is not yet possible without a master standard.

Source: Payerset

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Enforcement and Market Power

14T+

rate records from payor data and growing

Hospital files are easy to audit.

CSV format, millions of rows. Watchdog organizations can open and audit them directly.

Payor files are nearly impossible to audit

Multi-terabyte files across 10,000+ file sets. No government technology exists to systematically validate accuracy.

Ironically, large payors are benefiting.

Payors with the most market power and resources purchase this data to gain even more competitive intelligence.

Enforcement is improving.

There has been a new focus from CMS, and enforcement is getting better, especially with feedback from organizations like Payerset.

Insurers are using transparency data more than care delivery organizations, proactively reducing rates and battling competitors. This was not the intent of the federal law.

Source: Payerset

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Leveraging the Data

Payor Contract Negotiations

Service Line Planning and Market Growth

- What revenue risks or opportunities does our organization have by service line?
- What service lines exhibit demand for expansion and/or have market pricing vulnerabilities?

Defensible Pricing and CDM Alignment

- Are our charges market-competitive and defensible?
- Is there a consistent approach to our pricing strategy?
- Does our pricing align with our contracts?

Mergers and Acquisitions

- How do a target facility's payor rates line up with our organization?
- Do variances between specific service areas enable our combined entities to negotiate or market services differently?

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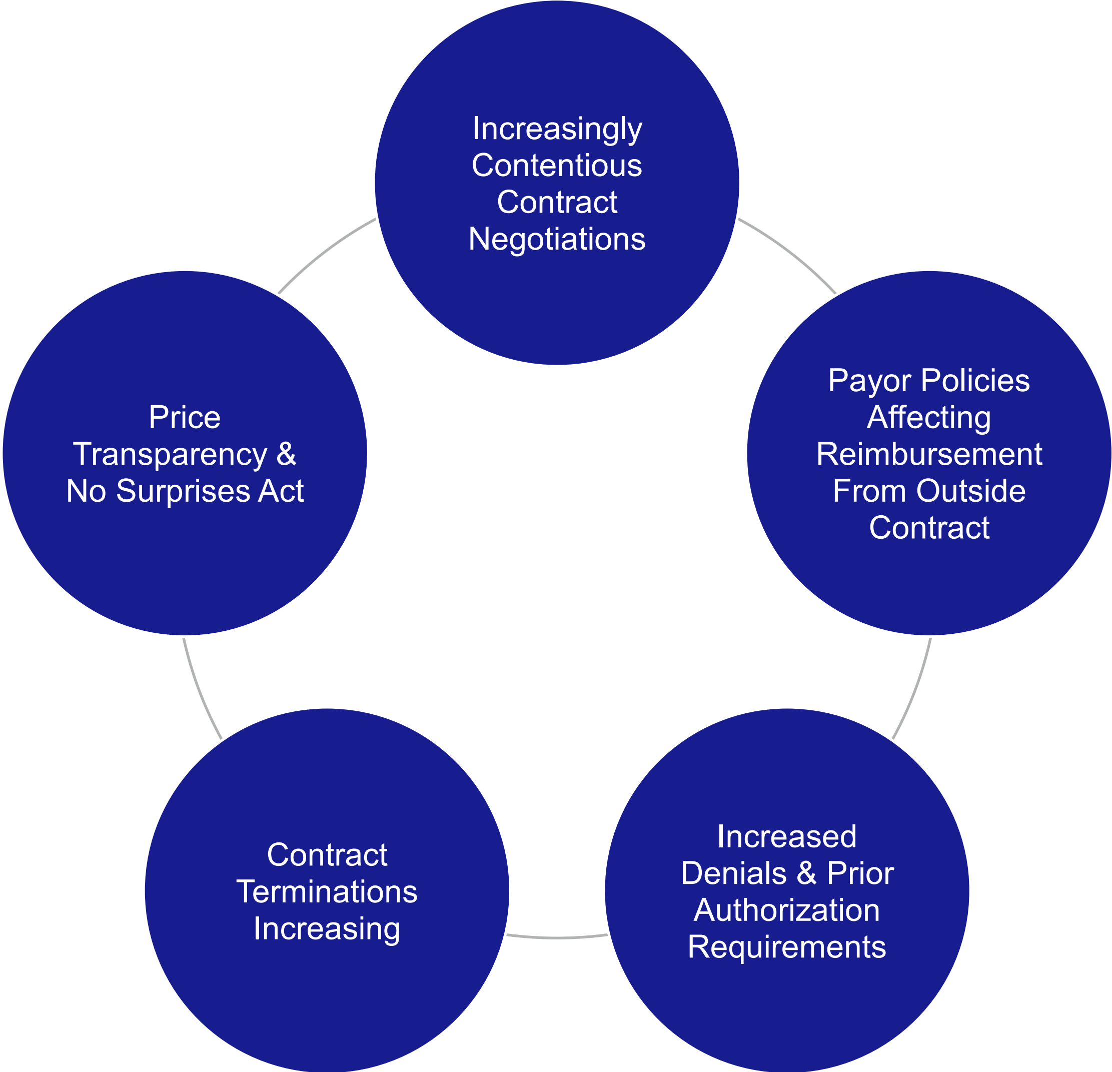
Payor/Provider Relationships



HOSPITALS, MEDCITY INFLUENCERS, PAYERS

Payer Negotiations Are Getting Ugly

As margins at health systems continue to contract, and insurance company profits continue to surge, contract negotiations are becoming increasingly contentious. With billions of dollars potentially at stake, you need to be prepared and aligned well in advance.

REIMBURSEMENT NEWS

Private payers initially deny nearly 15% of medical claims

Image sources: MedCity News, Becker's Hospital Review

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Contract Negotiations
Past vs. Present

	Past: “Trust Me”	Present: “Prove It”
Peer Rate Insights	Anecdotal	Publicly available
Rate Increases	Broad strokes; COLAs, CPIs	Service-line specific; strategic
Market Data & Analytics	Limited availability & less necessity	Publicly available & required
Strategic Focus	Volume & utilization	Value & population health; defensible pricing
External Involvement	Less engaged	More engaged
Network Participation	All providers, all payors	Strategic partnerships

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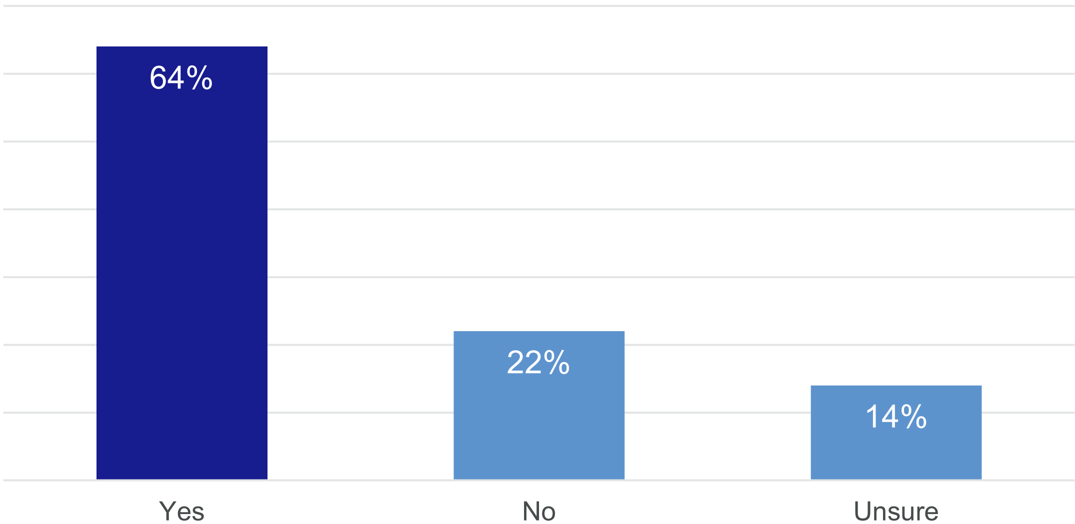
Executive Perspectives on Price Transparency Data

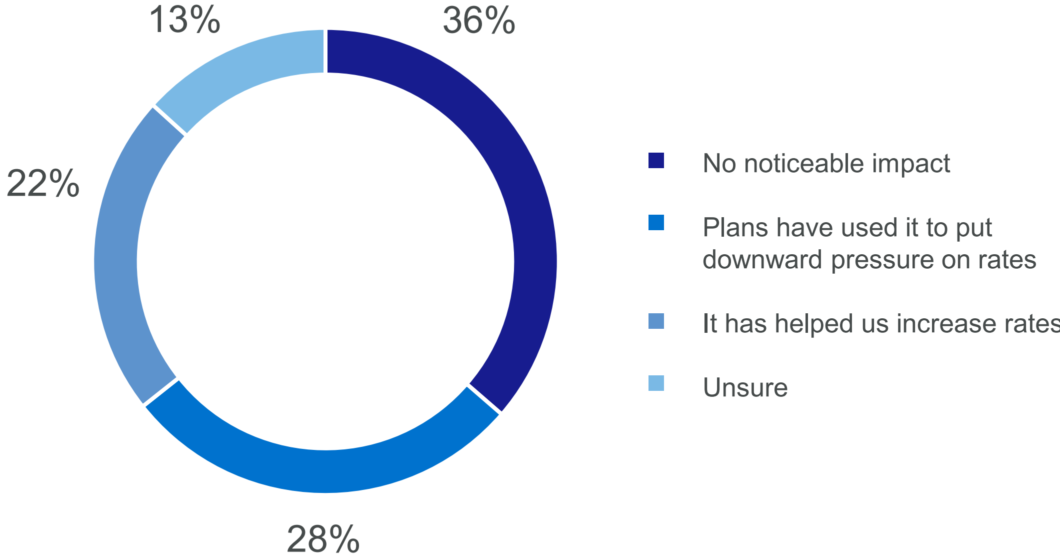
Do you access payor and hospital price transparency data to support managed care contract negotiations? (N=143*)



*Asked to respondents from hospitals/health systems and physician group practices.

While most hospital and health system executives are accessing price transparency data to support contract negotiations, the number has remained mostly static since 2025.

How has the availability of price transparency data impacted your negotiations with health plans? (N=143*)



*Asked to respondents from hospitals/health systems and physician group practices.

Only 22% of executives have seen success using price transparency data to negotiate more favorable rates. A larger percentage have seen health plans use the data to put downward pressure on rates during negotiations.

Percentages may not add to 100% due to rounding | Source: forvismazars.us/mindsets-2026

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Price Transparency for MAO Cost Report

Background

- Medicare Advantage Organizations (MAOs): private insurance plans that provide Medicare benefits to enrollees
- 2026 OPPS final rule finalized the policy to transition MS-DRG relative weights from cost-based (and cost-to-charge ratios) to actual negotiated MA rates
  - Approach will parallel the current MS-DRG logic, but market prices will replace estimated costs
  - The purpose is to support PPS inpatient reimbursement rates effective 2029
- Effective for cost reports ending January 1, 2026 and after
- Worksheet S-12 of the cost report
- CMS estimates time to complete is approximately 20 hours

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Current State: MS-DRG Calculations

Current

$$\text{Relative Weight} = \frac{\text{Average Resource (Charges to Cost) for the DRG}}{\text{National Average Resource Use (Charges to Cost) across all DRGs}}$$

Weight	Note
0.5	Half the average resource
1.0	Average resource
2.0	Twice the average resource

MS-DRG[1]	Description	Weight
795	Normal Newborn	0.1998
369	Major Esophageal Disorder with CC	1.0002
935	Non-Extensive Burns	2.0606

$$\text{Medicare Inpatient Payment} = \frac{\text{Operating Base Payment + Capital Base Payment}}{\text{Geographic Wage Index}}$$

x MS-DRG Relative Weight + Hospital Specific Adjustments

MS-DRG[1]	Description	Weight	Base Rate - $6,000
795	Normal Newborn	0.1998	$1,199
369	Major Esophageal Disorder with CC	1.0002	$6,001
935	Non-Extensive Burns	2.0606	$12,364

[1]MS-DRG values from the FY 2026 IPPS Final Rule Home Page

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Future State: MS-DRG Calculations

$$\text{MS-DRG Weight} = \frac{\text{Median MA Negotiated Payment by DRG}}{\text{National Average Median MA Payment across all DRGs}}$$

DRG	Median by DRG	Calculated Weight
1	$6,500	0.9493
2	$7,500	1.0953
3	$35,000	5.1117
4	$4,400	0.6426
5	$39,850	5.8200
National Median	$6,847	

DRG	Base Rate	Current Weight	Current Reimb.	Future Weight	Future Reimb.
1	$6,000	0.8975	$5,385	0.9493	$5,696
2	$6,000	1.2005	$7,203	1.0953	$6,572
3	$6,000	3.4756	$20,854	5.1117	$30,670
4	$6,000	0.9974	$5,984	0.6426	$3,856
5	$6,000	7.4856	$44,914	5.8200	$34,920
		Total	$84,340		$81,713[1]

[1]Variance due to rounding

[1]MS-DRG values from the FY 2026 IPPS Final Rule Home Page

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CMS Steps per the Federal Register

Step 1

Identify applicable Medicare MS-DRGs and negotiated reimbursement rates using the hospital's price transparency file.

Step 2

Calculate the total number of inpatient discharges by MA plan and MS-DRG for the cost report period.

Step 3

Combine negotiated rate data with discharge volume information to align utilization with payor-specific reimbursement.

Step 4

Calculate the median negotiated rate across all MA plans, reported at the MS-DRG level.

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CMS Steps per the Regulation

Step 1

- Identify the hospital's MAO from the current MRF (calculated rate or allowed amount), by MS-DRG[1]

Payor Plan	MS-DRG 003 Rate
MA1	$7,400
MA2	$7,200
MA3	$7,500
MA4	$7,150
MA5	$7,000

[1]MS-DRG values from the FY 2026 IPPS Final Rule Home Page

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CMS Steps per the Regulation

Step 2

- Sum the number of inpatient discharges by **cost report period** for each MAO, by MS-DRG[2]

Scenario 1: Even

Payor Plan	MS-DRG 003 Discharges
MA1	1
MA2	4
MA3	2
MA4	3
MA5	0
Total	**10**

Scenario 2: Odd

Payor Plan	MS-DRG 003 Discharges
MA1	1
MA2	4
MA3	2
MA4	1
MA5	1
Total	**9**

[1]MS-DRG values from the FY 2026 IPPS Final Rule Home Page

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CMS Steps per the Regulation

Step 3

- List each MS-DRG and include the specified negotiated charge and inpatient discharge for each MAO[3]

Step 4

- Calculate the median amount of all MAOs by MS-DRG for the cost report[4]

Even Scenario

Payor Plan	MS-DRG 003 Rate
MA4	$7,150
MA4	$7,150
MA4	$7,150
MA2	$7,200
MA2	$7,200
MA2	$7,200
MA2	$7,200
MA1	$7,400
MA3	$7,500
MA3	$7,500
Median Amount	**$7,200**

Odd Scenario

Payor Plan	MS-DRG 003 Rate
MA5	$7,000
MA4	$7,150
MA2	$7,200
MA2	$7,200
MA2	$7,200
MA2	$7,200
MA1	$7,400
MA3	$7,500
MA3	$7,500
Median Amount	**$7,200**

[1]MS-DRG values from the FY 2026 IPPS Final Rule Home Page

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Potential Risk

- When was the last time the MRF was updated?
- Does the MRF comply with the 2026 requirements (or most recent updates)?
  - Are the 10th, median, and 90th percentiles included?
- Are all contracted MA plans listed in the MRF?
- Have the 835 files been leveraged to support the calculation of the percentiles?
- Does the MRF reflect the data required to support MA negotiated rate reporting on the cost report?

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Thank you!

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Appendix

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3. https://www.federalregister.gov/d/2025-20907/p-4682
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5. FY 2026 IPPS Final Rule Home Page | CMS

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