

WEIGHTED MEDIAN MEDICARE ADVANTAGE ORGANIZATION
PAYER-SPECIFIC NEGOTIATED CHARGE DATA

Effective for cost reporting periods ending on or after January 1, 2026, subsection (d) hospitals, as defined at section 1886(d)(1)(B) of the Social Security Act (the Act), and subsection (d) Puerto Rico hospitals, as defined at section 1886(d)(9)(A) of the Act, must report the weighted median of the payer-specific negotiated charges the hospital has negotiated with each Medicare Advantage Organization (MAO) for each MS-DRG.

Hospitals exempted from completing this worksheet include:

- Hospitals that do not negotiate payment rates and only receive non-negotiated payments, for example, hospitals operated by an Indian Health Program as defined in section 4(12) of the Indian Health Care Improvement Act, or federally owned and operated facilities.
- Hospitals paid under the Maryland Total Cost of Care Model during the performance period of that model.

DEFINITIONS:

Items and services--All items and services, including service packages, provided by a hospital to a patient for an inpatient admission for which the hospital established a standard charge.

Machine-Readable File (MRF)--The price transparency file the hospital makes available to the public in accordance with 45 CFR 180.40(a).

Medicare Advantage Organization (MAO)--A public or private entity organized and licensed by a State as a risk-bearing entity, with the exception of provider-sponsored organizations receiving waivers, certified by CMS as meeting the MA contract requirements (42 CFR 422.2).

MAO payer-specific negotiated charge --The payer-specific negotiated charge that the hospital has negotiated with an MAO for inpatient items and services and made public under 45 CFR 180.50(b)(2)(ii), as listed in the hospital's most recent MRF as of the hospital's cost report filing date.

Medicare Severity Diagnosis Related Group (MS-DRG)--The classification of inpatient hospital discharges established under section 1886(d)(4) of the Act.

Payer-specific negotiated charge--The charge a hospital has negotiated with a third party payer for an item or service (45 CFR 180.20).

Weighted median MAO payer-specific negotiated charge--The weighted median of the MAO payer-specific negotiated charges weighted by the number of inpatient discharges for those payers that occurred during the cost reporting period.

INSTRUCTIONS

For each line, report the weighted median MAO payer-specific negotiated charge for each MS-DRG with discharges during the cost reporting period, determined as outlined below.

Some hospitals negotiate MAO payer-specific charge based on a non-MS-DRG system. When such a hospital identifies non-MS-DRG codes (in Step 1(b) below), or reports discharges not classified to MS-DRGs (in Step 2 below), the hospital must crosswalk those codes or classify those discharges to MS-DRGs. Hospitals can utilize the CMS Grouper and associated definitions manual for this purpose. Hospitals can access the publicly available version of the CMS Grouper used to group ICD-10 diagnosis and procedure codes to MS-DRGs (see <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software>). The hospital can use this software and accompanying definition manual to crosswalk the code in the MRF or classify the discharge to an MS-DRG code.

Step 1--Using its most recent MRF as of the cost report filing date, the hospital identifies the following:

(a) Each MAO payer-specific negotiated charge. For each MAO payer-specific negotiated charge based on a percentage or algorithm, the hospital must identify and substitute the dollar amount in the MRF required under 45 CFR 180.50(b)(2)(ii)(C) for the percentage or algorithm. Exclude any payer-specific negotiated charges that represent a capitated payment.

(b) The code under 45 CFR 180.50(b)(2)(iv)(A) for each payer-specific negotiated charge.

Step 2--For the cost reporting period, sum the number of inpatient discharges for each MAO for each MS-DRG. Exclude inpatient discharges where the hospital received payment on a capitated basis.

Step 3--For each MS-DRG, list each MAO payer-specific negotiated charge (from Step 1) once for each inpatient discharge that occurred during the cost reporting period for that MAO (from Step 2).

Step 4--For each MS-DRG, compute the median of the MAO payer-specific negotiated charges in the list from Step 3 by first ordering the list in Step 3 from the lowest to the highest MAO payer-specific negotiated charge; the hospital finds the median by identifying the middle value when the list contains an odd number of charges, or by calculating the mean of the two middle values when the list contains an even number of charges.

Example:

A hospital with a cost reporting period ending on September 30, 2026, negotiated MAO payer-specific negotiated charges for MS-DRG 123 for five MAOs, MA1, MA2, MA3, MA4, and MA5, during that cost reporting period.

The hospital filed its cost report on February 28, 2027.

The hospital made available to the public its price transparency MRF on January 1, 2027. This MRF did not contain MAO payer-specific negotiated charges for MA5 because the hospital stopped contracting with MA5 and began contracting with a new MAO, MA6.

Step 1--The hospital identified the following MAO payer-specific negotiated charge information for MS-DRG 123 from its January 1, 2027 MRF:

- MA1: \$7,400
- MA2: \$7,200
- MA3: \$7,500
- MA4: \$7,300 (algorithm-based)
- MA6: \$7,400

As the MAO payer-specific negotiated charge for MA4 was based on an algorithm, the hospital substituted the dollar amount in the MRF required under 45 CFR 180.50(b)(2)(ii)(C) for the algorithm.

Step 2--The hospital summed the number of inpatient discharges that occurred during the cost report period ending September 30, 2026, for each MAO for MS-DRG 123.

- MA1: 2 discharges
- MA2: 1 discharge
- MA3: 1 discharge
- MA4: 3 discharges
- MA5: 2 discharges

Step 3--The hospital listed each MAO payer-specific negotiated charge (from Step 1) the number of times as inpatient discharges that occurred during the cost reporting period for that MAO (from Step 2).

- MA1: \$7,400, \$7,400
- MA2: \$7,200
- MA3: \$7,500
- MA4: \$7,300, \$7,300, \$7,300

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The hospital listed the MRF charge of \$7,400 for MA1 twice because two MA1 discharges for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of \$7,200 for MA2 once because one MA2 discharge for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of \$7,500 for MA3 once because one MA3 discharge for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of \$7,300 for MA4 three times because three MA4 discharges for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed no MRF charge for MA5 as the hospital no longer contracted with MA5 and the hospital excluded the MRF charge of \$7,400 for MA6 as no MA6 discharges occurred during the cost reporting period.

Step 4--The hospital listed the seven amounts from Step 3 in order from the lowest to the highest MAO payer-specific negotiated charge. The median value is \$7,300 (as there is an odd number of items in the list the median is the middle number in the list).

- \$7,200 - MA2
- \$7,300 - MA4
- \$7,300 - MA4
- \$7,300 - MA4
- \$7,400 - MA1
- \$7,400 - MA1
- \$7,500 - MA3

The hospital reported the weighted median MAO payer-specific negotiated charge of \$7,300 for MS-DRG 123 on the Weighted Median MAO Payer-Specific Negotiated Charge Data Worksheet.

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