Supporting Statement A
Supplemental to Form CMS-2552-10: Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data
(CMS-10935; OMB 0938-New)

A. BACKGROUND

CMS requests that the Office of Management and Budget (OMB) review and approve this new collection, Supplemental to Form CMS-2552-10: Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data Worksheet, as finalized in the CY 2026 OPPS final rule (CMS-1834-FC) published November 25, 2025. This supplemental form advances the policy goal of increasing healthcare price transparency and promoting market-based approaches in Medicare FFS payments. The form requires hospitals to report, by MS-DRG, the weighted median of the payer-specific charges negotiated with Medicare Advantage organizations. The information reported on the worksheet enables CMS to calculate new IPPS MS-DRG relative weights beginning in FY 2029 and reinforces the administration's commitment to clear, accurate, and actionable healthcare pricing information.

B. JUSTIFICATION

1. Need and Legal Basis

Respondents participating in the Medicare program use Supplemental to Form CMS-2552-10: Median Payer-Specific Negotiated Charge Data Worksheet to report payer-specific negotiated charge data pursuant to the CY 2026 OPPS final rule published November 25, 2025. Sections 1815(a) and 1833(e) of the Act provide authority to collect data for purposes of determining the amount of payments due to a provider under the Medicare program. Specifically, sections 1815(a) and 1833(e) of the Act state that no Medicare payments will be made to a provider unless it has furnished information requested by the Secretary to determine payment amounts due under the Medicare program. Section 1886(d)(4) of the Act authorizes CMS to assign and update MS-DRG weighting factors to reflect relative resource use. In particular, section 1886(d)(4)(B) of the Act requires that for each diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups, and section 1886(d)(4)(C)(i) of the Act requires that the weighting factors be adjusted at least annually to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. To fulfill these statutory requirements for accurate MS-DRG weighting and payment determination while advancing price transparency initiatives, this form supports the policy goal of increasing healthcare price transparency and implementing market-based approaches in Medicare FFS payments. It requires hospitals to report, by MS-DRG, the weighted median payer-specific negotiated charges with Medicare Advantage organizations, enabling CMS to calculate IPPS MS-DRG relative weights starting FY 2029, based on the reported data rather than on gross charges from hospital chargemasters, and advancing the administration's commitment to clear, accurate, and actionable healthcare pricing information. The existing Medicare cost reporting Form CMS-2552-10 (OMB #0938-0050) does not currently capture the necessary market-based payment rate data. Therefore, hospitals need this supplemental worksheet to report the data for cost reporting periods ending on or after January 1, 2026.

2. Information Users

This supplemental form provides a standardized worksheet for hospitals to report their median payer-specific negotiated charges with Medicare Advantage organizations. CMS will use this market-based data to calculate IPPS MS-DRG relative weights beginning in FY 2029, replacing the current system of using gross charges from hospital chargemasters.

3. Use of Information Technology

CMS regulations at 42 CFR § 413.24(f)(4)(ii) require that each hospital submit its annual cost report to its contractor in a standard (ASCII) electronic cost report (ECR) format. This supplemental form must accompany the hospital's annual cost report for cost reporting periods ending on or after January 1, 2026.

4. Duplication of Efforts

This information collection duplicates no other effort and CMS cannot obtain the information from any other source.

5. Small Businesses

While CMS requires that all hospitals complete the Medicare cost report, only subsection (d) hospitals and subsection (d) Puerto Rico hospitals must complete the Weighted Median Payer Specific Negotiated Charge Data Worksheet, excluding hospitals that do not negotiate payment rates such as Indian Health Program hospitals. Hospitals paid under the Maryland Total Cost of Care Model are exempt from completing the worksheet during the performance period of that Model. CMS designed this supplemental form with a view toward minimizing the reporting burden for all hospitals completing the form. CMS collects the form as infrequently as possible (annually) and limits the reporting requirement to data for MA organization-paid discharges from the cost reporting period.

6. Less Frequent Collection

This supplemental form must accompany the hospital cost report, Form CMS-2552-10. Under the authority of 1861(v)(1)(F) of the Act, as defined in regulations at 42 CFR 413.20 and 413.24, CMS requires that each hospital submit the cost report on an annual basis with the reporting period based on the hospital's accounting period, which is generally 12 consecutive calendar months. A less frequent collection would adversely affect provider payments.

7. Special Circumstances

This information collection complies with all general information collection guidelines as described in 5 CFR 1320.6 without the existence of special circumstances.

8. Federal Register Notice

The 60-day Federal Register notice was part of the proposed rule (CMS-1834-P; RIN 0938-AV51) that published on July 17, 2025 (90 FR 33476).

The 30-day Federal Register notice was part of the final rule (CMS-1834-FC) that published on November 25, 2025 (90 FR 53448).

9. Payment/Gift to Respondent

CMS makes no payments or gifts to respondents for completion of this data collection, a supplemental form to the cost report, Form CMS-2552-10. CMS issues claims payments for covered services provided to Medicare beneficiaries. The cost report collects data to determine accurate payments to the hospital. If the hospital fails to submit the cost report, the contractor imposes a penalty by suspending claims payments until the hospital submits an acceptable cost report, including this supplemental form. Once the hospital submits an acceptable cost report, the contractor releases the suspended payments. A hospital that submits its cost report timely, with this required supplemental form, experiences no interruption in claims payments.

10. Confidentiality

The Freedom of Information Act permits public access to Medicare cost reports. CMS cannot guarantee confidentiality and pledges to maintain privacy to the extent provided by law.

11. Sensitive Questions

The form includes no questions of a sensitive nature.

12. Estimate of Burden (Hours and Cost)

Number of respondents		3,038
Hours burden per respondent		20
Reporting	15	
Recordkeeping	5	
Total hours burden (3,038 facilities x 20 hours)		60,760
Cost per respondent		1,598.90
Total annual cost estimate (1,598.90 x 3,038 respondents), rounded		4,857,458

CMS estimates additional burden for the required recordkeeping and reporting only when the standardized definitions, accounting, statistics and reporting practices defined in 42 CFR 413.20(a) require reporting or recordkeeping not already maintained by the provider on a fiscal basis.

Burden hours for each hospital estimate the time required (number of hours) to complete ongoing data gathering and recordkeeping tasks, search existing data resources, review instructions, and complete the Supplemental to Form CMS-2552-10, Weighted Median Medicare Advantage Organization Payer-Specific Negotiated Charge Data Worksheet. The

most recent data from the System for Tracking Audit and Reimbursement (STAR), an internal CMS data system maintained by the Office of Financial Management (OFM), tracks the current number of Medicare-certified respondents required to submit the supplemental form as 3,038, which file annually. We estimate an average burden per respondent of 20 hours (15 hours for reporting and 5 hours for recordkeeping). We recognize this average varies depending on the provider size and complexity. We invite public comment on the hours estimate as well as the staffing requirements utilized to compile and complete the supplemental form.
We calculated the annual burden hours as follows: 3,038 respondents multiplied by 20 hours per respondent equals 60,760 annual burden hours. The 15 hours for reporting include hours for accountants and auditors; the 5 hours for recordkeeping include hours for bookkeeping, accounting and auditing clerks.

The May 2024 Bureau of Labor Statistics Occupation Outlook Handbook reports a mean hourly wage of $44.96 for Category 13-2011 (accountants and auditors). Adding 100% for fringe benefits and overhead doubles the hourly rate to $89.92. Multiplying $89.92 by 15 hours yields annual reporting costs of $1,348.80 per respondent.

The May 2024 Bureau of Labor Statistics Occupation Outlook Handbook reports a mean hourly wage of $25.01 for Category 43-3031 (bookkeeping, accounting and auditing clerks). Adding 100% for fringe benefits and overhead doubles the hourly rate to $50.02. Multiplying $50.02 by 5 hours calculates to $250.10 in annual reporting costs per respondent.

Adding the per respondent reporting cost of $1,348.80 and recordkeeping cost of $250.10 yields a total average annual cost of $1,598.90 per respondent. Multiplying this amount by 3,038 respondents results in a total annual cost of $4,857,458 (rounded to the nearest dollar).

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

This information collection creates no additional costs for the Federal Government because contractors process this worksheet electronically as part of the hospital's electronic submission of the Form CMS-2552-10, Hospital and Hospital Healthcare Complex Medicare Cost Report. The cost to the Federal Government for processing the Form CMS-2552-10 includes:

Annual cost to MACs	$64,878,604
Annual cost to CMS	$74,301
Total Federal cost	$64,952,905

15. Changes to Burden

This represents a new information collection.

16. Publication and Tabulation Dates

CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). The HCRIS data supports CMS's reimbursement policymaking, congressional studies, legislative health care reimbursement initiatives, Medicare profit margin analysis, market basket weight updates, and public data requirements. CMS publishes the HCRIS dataset for public access and use at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/.

17. Expiration Date

CMS displays the expiration date on the first page of the data collection instrument in the upper right corner and in the instructions.

18. Certification Statement

There are no exceptions to the certification statement.

C. STATISTICAL METHODS

There are no statistical methods involved in this collection.