The Market-Driven Shift:
What Worksheet S-12 Means for Hospital Reimbursement

Beginning with cost reporting periods ending on or after **January 1, 2026**, IPPS hospitals must complete the new **Worksheet S-12.**

This new worksheet requires providers to cross-reference their Price Transparency Machine-Readable Files (MRFs) with patient accounting data to disclose the weighted median payment rates negotiated with Medicare Advantage Organizations (MAOs).

What sounds like a standard compliance update is actually a profound paradigm shift: **CMS intends to use this data to reshape traditional Fee-For-Service (FFS) Medicare rate-setting by FFY 2029** with the goal to align traditional Medicare reimbursement more closely with prevailing healthcare market dynamics.

What is Worksheet S-12 and Why Does It Matter?

Traditionally, Medicare has calculated hospital inpatient payment rates using historical hospital cost data. Under this methodology, the Centers for Medicare & Medicaid Services (CMS) established Medicare Severity Diagnosis-Related Group (MS-DRG) relative weights by applying Cost-to-Charge Ratios (CCRs) to hospital charges to approximate the underlying cost of care.

Worksheet S-12 requires hospitals to report, by MS-DRG, the weighted median of MAO payer-specific negotiated charges.

To complete the worksheet, hospitals must use the most recent machine-readable file (MRF) available as of the cost report filing date to identify MAO negotiated charges. These charges must then be aligned to MS-DRGs and weighted, using Medicare Advantage inpatient discharge volume from the cost reporting period.

While the reporting requirements themselves are significant, the broader implication is even more important. CMS intends to use the MAO negotiated charge data collected through Worksheet S-12 to support future inpatient payment policy. As a result, Worksheet S-12 represents one of the first major steps toward incorporating Medicare Advantage negotiated rate data into how traditional Medicare inpatient payment rates are determined.

How This Data Could Reshape Medicare Payments

The reported data is expected to influence future inpatient payment policy through several important mechanisms:

Shifting Away from Cost-Based Estimation

Rather than hospital charge data and CCR methodologies to approximate the relative resource intensity of inpatient services, Worksheet S-12 will be the new source of information that CMS intends to incorporate into future inpatient rate-setting methodologies.

Incorporating Market-Based Pricing Signals

By evaluating MAO negotiated charge data across MS-DRGs, CMS will gain additional insight into how inpatient services are valued within the Medicare Advantage marketplace. Over time, these market-based pricing signals may influence how CMS determines relative weights across clinical services and procedures.

Redistributing Payments Across Service Lines

Federal law requires the transition to remain budget neutral, meaning the change is not intended to increase or decrease overall Medicare spending. Instead, adjustments to MS-DRG relative weights will redistribute reimbursement across service lines, with some services benefiting from higher relative weights while others experience downward pressure.

Preparing for Worksheet S-12 Compliance

While the reimbursement implications of Worksheet S-12 will not be fully realized for several years, the compliance requirements begin immediately. Hospitals must establish processes to identify MAO negotiated charge data, align those charges to MS-DRGs, validate discharge volumes, and ensure data consistency across multiple systems and departments.

CMS estimates the collection and validation process will require approximately 20 hours annually per hospital. However, the operational burden may be considerably greater for organizations with complex managed care agreements, decentralized contract management processes, or non-MS-DRG-based reimbursement methodologies.

Successfully completing Worksheet S-12 will require collaboration across Managed Care, Reimbursement, Revenue Integrity, Health Information Management (HIM), Finance, and Information Technology teams. Organizations that begin assessing their data sources and reporting workflows now will be better positioned to meet future reporting requirements and adapt to the evolving reimbursement landscape.

Navigating the Market Shift: How Meduit Protects and Empowers Your Hospital

The transition to Worksheet S-12 introduces immediate administrative strain and long-term revenue volatility. Hospital leadership cannot afford to treat this as a standard, routine cost-reporting update.

For years, hospitals have trusted Meduit to maximize historical revenue through industry-leading Medicare Bad Debt (MBD) and Worksheet S-10 solutions. As the regulatory landscape evolves, we evolve with you. Our team serves as both a trusted operational partner and strategic advisor, helping hospitals navigate evolving reimbursement requirements while preparing for future payment methodology changes. Our support focuses on these key areas:

- **Optimizing Medicare Advantage Contract Positioning:** We help organizations evaluate their Medicare Advantage reimbursement position and understand how evolving market-based reimbursement methodologies may affect future reimbursement strategies.
- **Mitigating DRG-Level Reimbursement Risks:** Meduit goes beyond basic data entry. We evaluate high-volume clinical service lines to identify MS-DRGs that may be more susceptible to future reimbursement pressure and revenue risk.
- **Ensuring Price Transparency Data Integrity:** Worksheet S-12 relies heavily on accurate underlying data. We help validate and assess MRF data used in Worksheet S-12 reporting, supporting accuracy, compliance, and cost report readiness.
- **Model the Impact:** Cross-reference your MAO negotiated rates with current MS-DRG weights to identify potential reimbursement revenue drops.
- **Align Your Teams:** Ensure teams are actively communicating to prevent unintended pricing compliance risks.

Need help navigating the new reporting requirements?

Contact our Government Reimbursement team today at **GovtReimbursement@meduitrcm.com** to schedule a comprehensive data readiness assessment.

Sources

- Centers for Medicare & Medicaid Services. (2025). 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
- Definitive Healthcare. (2025). Healthcare cost reporting information system. https://www.definitivehc.com/resources/glossary/healthcare-cost-reporting-information-system
- Ericson, C. (2025, December). Incorporating Medicare Advantage Beneficiaries into Medicare Data. https://medlearn.com/icd10monitor/incorporating-medicare-advantage-beneficiaries-into-medicare-data/
- FORM CMS-2552-10. (2026, June). https://www.costreportdata.com/instructions/Instr_S120.pdf
- Franco, M. A. (2026). CMS releases CY 2026 hospital OPPS and ambulatory surgical center final rule. https://www.hklaw.com/en/insights/publications/2025/11/cms-releases-cy-2026-hospital-opps-and-ambulatory-surgical-center
- Hammond, J. (2025). New Medicare Payment Rules (OPPS and PFS) Show Trump Administration's Focus on Site Neutral Payments and Reducing Medicare's Market Distortions. https://paragoninstitute.org/medicare/new-medicare-payment-rules-opps-and-pfs-show-trump-administrations-focus-on-site-neutral-payments-and-reducing-medicares-market-distortions/