Feedback Summary & Discussion - Draft Uniform Reporting Manual and Submission Schedule

Key Themes and Proposed Actions

Diamond State Hospital Cost Review Board
April 17, 2026

Meeting Agenda

Agenda Item	Time
• Welcome and Introductions • Review of Agenda	10:00 AM – 10:10 AM
• Review & Discussion: • Feedback Received on Draft Uniform Reporting Manual & Submission Schedule	10:10 AM – 12:15 PM
• Next Steps & Close	12:15 PM – 12:30 PM

Review and Discussion: Feedback Received on Draft Uniform Reporting Manual and Submission Schedule

Draft Uniform Reporting Manual and Submission Schedule: Feedback

Hospital Technical Working Session

March 31, 2026

Participation by:

- ChristianaCare
- Beebe Healthcare
- Nemours
- BayHealth
- TidalHealth
- Trinity Health/St. Francis Hospital

Written Feedback

Due date: April 10, 2026

Submitters:

1. Delaware Hospital Association
2. ChristianaCare

Summary of Key Issues Raised in Feedback

1. Process and Engagement: The Delaware Hospital Association (DHA) and ChristianaCare requested additional engagement before the Uniform Reporting Manual (URM) is finalized; DHA is developing a crosswalk of existing reporting requirements mapped to the draft URM estimated to be complete week of 4/13.

2. Submission Schedule for Annual Review: Hospitals indicate that the submission schedule as initially proposed is too compressed. The submission schedule must account for hospitals' differing fiscal years.

3. Reporting Burden: Most URM elements are already reported per Medicare Cost Reports, IRS Form 990s, Audited Financial Statements and bondholder disclosures. DHA and ChristianaCare recommend the Board leverage existing submissions, rather than require hospitals to populate a separate template.

4. **Scope:** Questions were raised as to whether some URM elements fall out of scope, particularly those capturing revenues and expenses from affiliated entities and system-level operations. Access to care metrics were raised as potentially out of scope.

5. Confidentiality: DHA and ChristianaCare emphasized that safeguards must be in place to protect proprietary information.

1. Process and Engagement

Issue: DHA urged the Board to provide time for additional hospital working sessions to identify key issues and refine the draft URM.

Option	Considerations
Option 1: Convene additional public working session with hospitals.	• An additional work session may further clarify technical issues and raise solutions for inclusion in the Regulation prior to submission. • Additional time to schedule and host working session will delay timeline for Regulation draft.
Option 2: Re-open written comment period to receive additional hospital feedback.	• Addresses requests for additional time to identify technical issues before the Administrative Regulation is submitted to the Registrar. • Likely to delay timeline for completing Regulation draft.
Option 3: Proceed with Regulation draft, incorporating feedback received to-date where appropriate.	• Hospital stakeholders were provided opportunity to review and comment on the URM from March 24 – April 10. A technical working session was held to invite hospital feedback on March 31. • Maintains Administrative Regulation drafting timeline. • Potential for greater volume of feedback during public comment period after the Regulation is posted.

1. Process & Engagement: Draft Administrative Regulation Timeline

Activity	Option 1 (current timeline)	Option 2 (extended timeline for additional feedback)
Gather feedback from Hospital Stakeholders, synthesize, and share back with Board	March 24 – April 10	March 24 – May 12
FHC prepares a plain-language Administrative Regulation, revising the initial draft of the Uniform Reporting Manual and Review Schedule based on feedback received (including April 10 hospital feedback, April 17 DSHCRB meeting input, and any additional comments or meetings).	April 17 – May 4	April 17 – May 22
FHC share draft plain language draft regulation to be distributed to DSHCRB (1 week prior to Board Meeting)	May 5	June 2
Discuss plain language admin regulation during DSHCRB Meeting & get board feedback	May 12	June 9
Plain language Administrative Regulation submitted to DOJ/Deputy Attorney General for drafting	April 24 – May 27	June 9 – July 7
Draft Administrative Regulation shared with Board	June 2nd	July 7
Board to vote on draft Administrative Regulation during DSHCRB Meeting	June 9	July 14
Submit revised draft Administrative Regulation to Registrar	June 15	July 15
Proposed Administrative Rule Published	July 1	August 1
Public Comment Period	July 1- July 30	August 1 – August 30
Public Hearing (if applicable)	July 21 (earliest possible date for hearing)	August 21 (earliest possible date for hearing)
Extended Public Comment Period if there is Public Hearing	August 5	September 8
Final Regulation Submitted	August 15	September 15
Final regulation and Order are published	September 1	October 1
Regulation goes into effect	September 11	October 13

2. Submission Schedule and Annual Review

Issue: Hospitals indicated that the submission schedule as proposed is too compressed. The submission schedule must account for hospitals' differing fiscal years

Option	Considerations
Option 1: Uniform submission schedule for all hospitals incorporating additional time for Board of Manager approval of Audited Financial Statements.	• Standardizes submission timeline and review period. Better enables public participation. • Financial data for the one hospital operating on a different fiscal year will be lagged.
Option 2: Staggered submission based on each hospital's fiscal year end.	• Separate review periods would allow all hospitals' financial data to be evaluated within the same number of days from fiscal year end. • Two submission cycles increase resource requirements for Board review and may complicate public participation.
Option 3: Utilize the previously proposed timeline for Option 1 or 2.	• Shortens submission timeline and review period relative to Option 1 or 2.

Hospitals shall annually submit to the Board any of the following information required by the Board under rules, regulations, and guidance promulgated under this subchapter, including the Manual:
(1) The hospital's expenditures and revenues for the most ***recently completed fiscal year****, including the financial information described in paragraph (a)(2) of this section****, redlined to reflect increases and changes from the fiscal year immediately preceding such fiscal year****.*

Option 1

July–June FY (FY2026, ends Jun 30, 2026)

Jan–Dec FY (FY2025, ends Dec 31, 2025)

July–June Fiscal Year

Jun 30, 2026
0
FY end
(most hospitals)

Nov 27, 2026
150
Audited financials
approved by BOM

Jan 16, 2027
200
Data submission
Current + prior yr redlined

Feb–Mar 2027
230
Staff review

April+
230+
Hospital presentations & final review

Both FYs submit Jan 2027

January–December Fiscal Year

Dec 31, 2025
0
FY end
(calendar-year hospitals)

May 30, 2026
150
Audited financials
approved by BOM

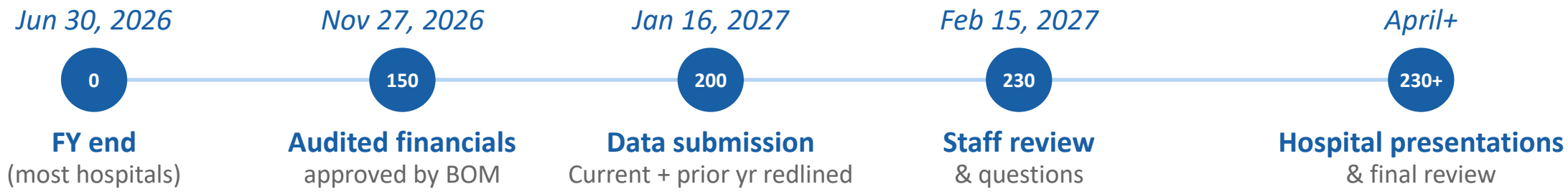
Jan 16, 2027
382
Data submission
Same deadline as Jul–Jun FY

Option 2

July–June FY (FY2026, ends Jun 30, 2026)

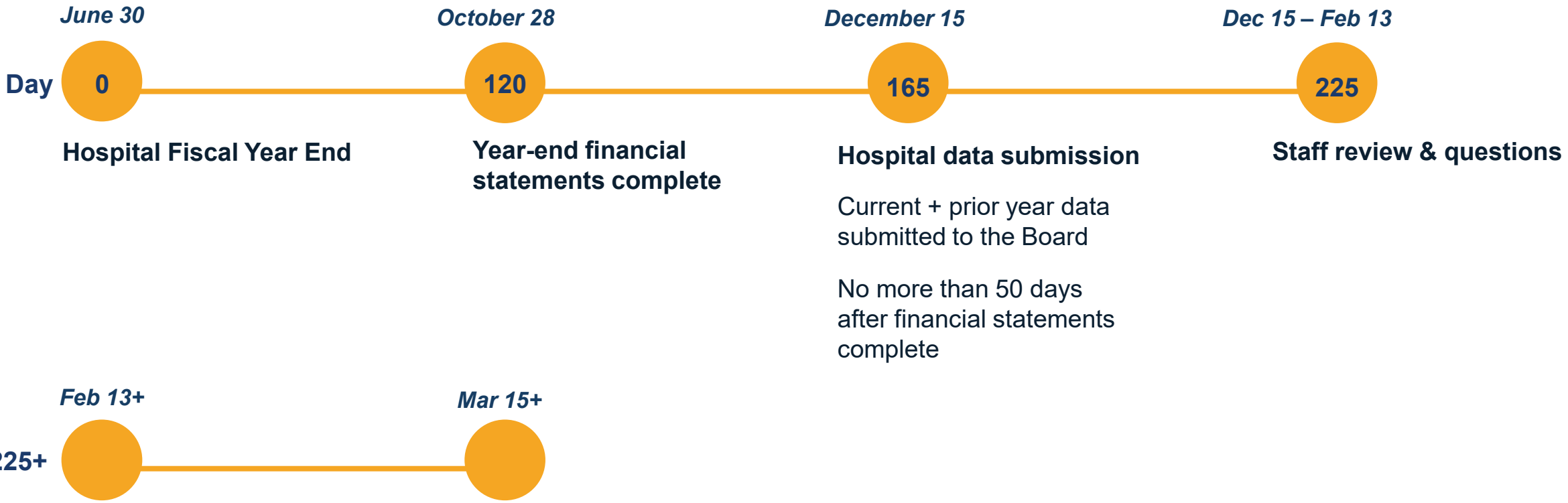
Jan–Dec FY (FY2026, ends Dec 31, 2026)

July–June Fiscal Year



January–December Fiscal Year

Option 3: Original Proposed Submission Schedule



3. Reporting Burden

Issue: Most elements specified by the URM are already reported by hospitals per Audited Financial Statements, Medicare Cost Reports, etc. DHA and ChristianaCare recommend the Board leverage existing submissions, rather than require hospitals to populate a separate template.

Option	Considerations
Option 1: Collect copies of AFS with a single "red-lined" exhibit showing changes between fiscal years.	• Reduces reporting burden for hospitals. • Significantly increases analytical work for the Board which would be required to standardize the submissions for review. • Hospitals may not agree with calculations or other derivatives of the information. • The Board would have less information available to determine hospitals' cost drivers.
Option 2: Simplify the list of proposed exhibits (e.g. remove access to care measures, Executive Compensation).	• Simplifies reporting while enabling hospitals to prepare and validate. • Requires hospitals to complete a new report template; reporting elements are consistent with other reporting obligations.
Option 3: Collect full list of proposed exhibits.	• Reduces potential number of future amendments to the Administrative Regulation by incorporating more elements from the start. • Requires hospitals to complete a new report template; reporting elements are consistent with other reporting obligations.

4. Scope

Issue: Hospitals raised whether some URM elements fall out of scope, particularly those capturing revenues and expenses from affiliated entities and system-level operations as well as access to care measures.

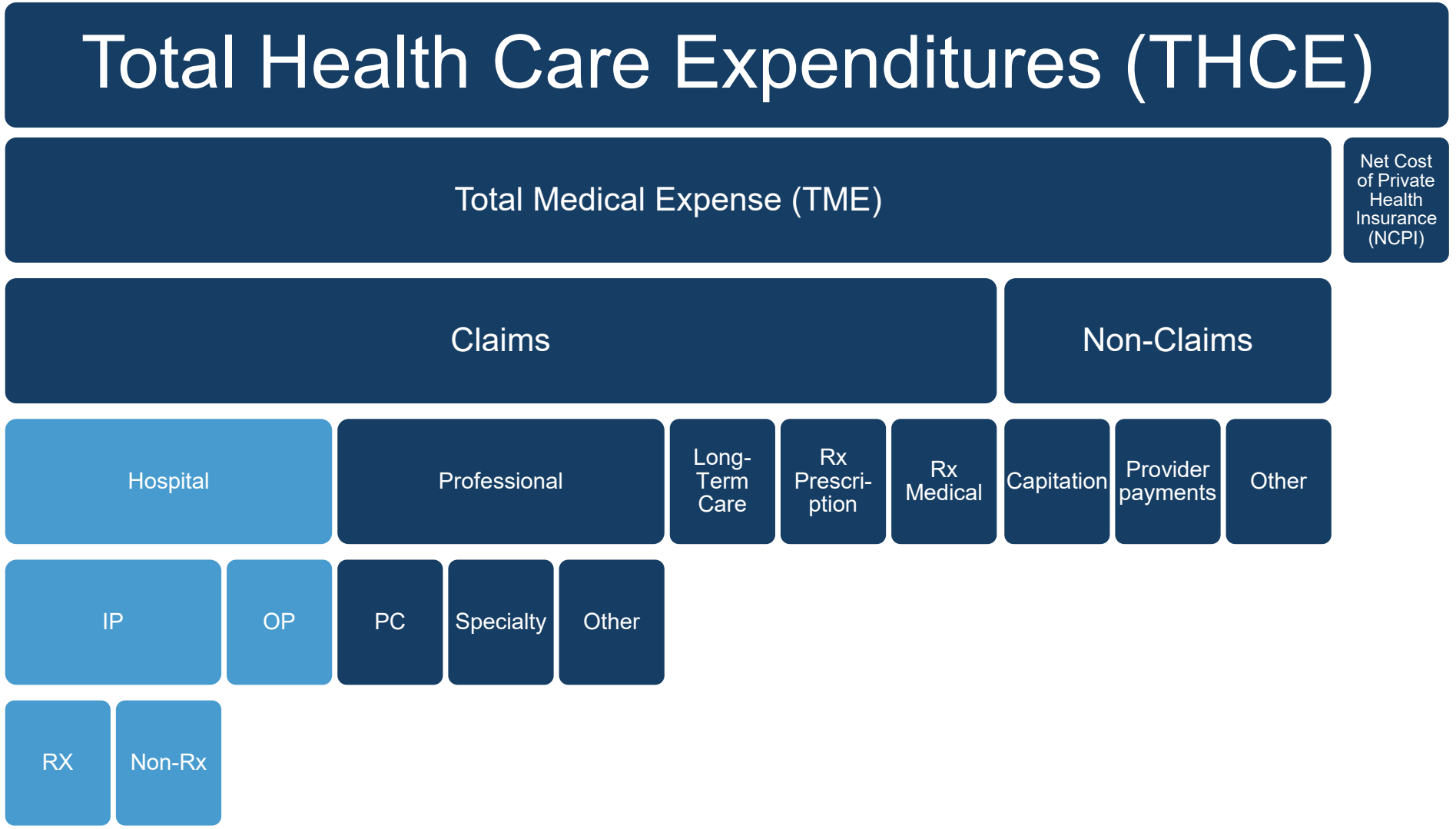
Option	Considerations
Option 1: Ensure reporting includes operating and non-operating information at the consolidated and CMS Certification Number (CCN) Levels; per the URM, regulated hospitals subject to Board jurisdiction should be separated from non-regulated system level information.	• The Board should have a complete financial picture and the submitters need to indicate whether the information is relative to the regulated entity or not. • Including system-level factors helps ensure data is properly contextualized and supports a more accurate understanding of hospital finances and reporting
Option 2: Remove access-to-care measures	• Simplifies reporting. • Access-to-care measures present meaningful information for the Board to consider relative to hospital costs as suppressed utilization from access barriers can shift care to more expensive settings.

5. Confidentiality

Issue: Hospitals emphasized that safeguards must be in place to protect proprietary information.

Considerations
• Data elements identified in the URM map to reporting that is already in the public domain. • Hospitals should identify which elements are considered proprietary.

Total Health Care Expenditure Benchmark



- Hospital revenue is only one component of the THCE.
- Health systems may deliver TME services, but the payment is not directed to a hospital (e.g., provider groups billing independently).
- THCE includes medical care delivered to Delaware residents at hospitals ***in and out of state***. The current data collection does not disaggregate spending based on where care was delivered.
- THCE Benchmarks are for a CY, whereas most hospitals operate on a July to June fiscal year (FY).

Hospital Stakeholder Meeting Feedback & Written Feedback

Meeting Feedback

Feedback	Section	Recommendation
Improve definition of “Regulated Hospital” to encompass all hospitals subject to financial information analysis submission. Current language of “General Acute Hospital” does not typically include a pediatric tertiary care center.	Section 1 – Definitions, 1	Revise
Suggestion to revise “Emergency Department Services” definition from “individuals requiring immediate evaluation or treatment” to “patients presenting to the Emergency Department for care.”	Section 1 – Definitions, 2	Revise
Suggestion to revise definition of Full Time Equivalents and replace the hour threshold with alternative language to capture all employees considered to be Full Time, regardless of precise hours worked; suggestion to consider capturing overtime. Request reports of hours worked and apply considered FTEs per industry conventions.	Section 1 – Definitions, 3	Revise
Observation that “historical cost” is not universally applicable; some assets must be recorded at fair market value. Suggestion to revise, “Assets and liabilities should be stated utilizing the appropriate methodology required by generally accepted accounting principles (GAAP). Donations should be recorded at the fair market value at the time of donation. When GAAP allows for more than one method of valuation, disclosure should be made within the audited financials of the method utilized by the entity.”	Section 2 – AFS, 3	Revise
Requested modifying timeline for submitting audited financial statements from “30 days of completion” to “x# of days from Board approval”	Section 2 – AFS, 3	Revise URM to specify AFS submission in accordance with annual schedule of review.
Recommended incorporating FASB and related references by citation to avoid future regulatory amendments.	Section 2 – AFS, 3	Revise
Suggestion to add a separate row for hospital employees in hospital self-insured plan, broken out from commercial.	Section 3 - Net Patient Revenue by Payer	Revise
Suggestion to explicitly name expected categories for NPs, PAs, and related clinical staff. Could potentially group with Provider (Section 5), but should be explicit	Section 3 - Net Patient Revenue by Payer	Revise
Note that IRS 990s are complete 320 days from close of fiscal year.	Submission Schedule	Reference publicly available 990s, even if lagged, as necessary.

Additional Written Feedback

	Original	Recommended Update
Technical reference error: Net Patient Revenue	Worksheet G, Part I, Col 1, Line 24	Worksheet G-3, Line 3
Technical reference error: **Total** Costs	Worksheet A, Column 26	Worksheet B, Part I, Column 26, Line 200
Review DHA crosswalk for potential technical changes		Update pending review of crosswalk

Closing & Next Steps

Thank you.

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