Continuing Discussion of Administrative Regulation to Support Annual Review of Hospital Financial Information

Diamond State Hospital Cost Review Board
May 12, 2026

Meeting Agenda

Agenda Item	Time
Welcome	10:00 AM – 10:05 AM
Benchmark Updates from Secretary	10:05 AM – 10:30 AM
Updated Draft Administrative Regulation Timeline	10:30 AM – 10:40 AM
Continued Discussion: Key Issues and Recommendations for Draft Administrative Regulation	10:40 AM – 11:20 AM
Outstanding Topic Areas	11:20 AM – 12:00 PM
Deputy Attorney General Guidance	12:00 PM – 12:20 PM
Next Steps & Close	12:20 PM – 12:30 PM

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Updated Draft Administrative Regulation Timeline

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Administrative Regulation Timeline

Activity	Date
Gather feedback from Hospital Stakeholders, synthesize, and share back with Board	March 24 – April 27
FHC prepares a plain-language Administrative Regulation, revising the initial draft of the Uniform Reporting Manual and Review Schedule based on feedback received to date	April 27 – June 1
FHC shares draft plain-language regulation with DSHCRB (1 week prior to Board Meeting)	June 2
Discuss plain-language admin regulation during DSHCRB Meeting & get board approval	June 9
Plain-language Administrative Regulation submitted to DOJ/Deputy Attorney General for drafting	June 9 – June 12
DOJ/Deputy Attorney General drafts regulation	June 12 – July 10
Draft Administrative Regulation shared with Board	July 14
Board to vote on draft Administrative Regulation during DSHCRB Meeting	July 21
Submit Proposed Administrative Regulation to Registrar	August 14
Proposed Administrative Regulation Published	September 1
Public Comment Period	September 2 – October 6
Public Hearing (if applicable)	September 21 (earliest possible date for hearing)
Public Comment Period Closes (extended if there is a Public Hearing)	October 6
Final Regulation Submitted	October 7
Final Regulation and Order are published	November 2
Regulation goes into effect	November 12

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Continued Discussion: Key Issues and Recommendations for Draft Administrative Regulation

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Summary of Key Issues Raised in Feedback Reviewed April 17, 2026

1. Process and Engagement: The Delaware Healthcare 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 completed 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.

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1. Process and Engagement: Draft Administrative Regulation

Additional work session held (Work Session 2) in response to request for more engagement.

Summary of Hospital Work Session Participation and Written Feedback

Work Session 1 March 31, 2026	Written Feedback April 10, 2026	Work Session 2 April 27, 2026	Written Feedback May 1, 2026
• ChristianaCare • Beebe Healthcare • Nemours • BayHealth • TidalHealth • Trinity Health/St. Francis Hospital • Delaware Healthcare Association	• Delaware Healthcare Association • ChristianaCare	• ChristianaCare • Beebe Healthcare • Nemours • BayHealth • TidalHealth • Trinity Health/St. Francis Hospital • Delaware Healthcare Association	• Delaware Healthcare Association • Nemours

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2. Submission Schedule for Annual Review: **Updated**

■ July–June FY (FY2026, ends Jun 30, 2026) ■ Jan–Dec FY (FY2025, ends Dec 31, 2025)

July–June Fiscal Year

Both FYs submit Jan 2027

January–December Fiscal Year

Hospital Financial Information Submission Proposed for January 31 or the next business day if the 31st falls on a weekend.

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3. Reporting Burden and 4. Scope

- FHC recommends simplifying the Uniform Reporting Manual to primarily encompass elements already reported in Medicare Cost Reports and Audited Financial Statements.

Proposed Simplification	Statutory Requirement
Remove IRS 990-like information (Sections 1.5 and 5) from submission requirements and instead access the information already reported and available in the public domain.	*(5) Consider the salaries for the hospital's executive and clinical leadership whose compensation is publicly disclosed in the hospital's Internal Revenue Service Form 990 filings*.
Remove Access to Care measures (Section 7.3C) from submission requirements; the Board can access and consider Quality of Care information already publicly reported to CMS, the State, and other existing sources.	(7) *Other information the Board determines to be relevant to the Board's obligations under this section…*
Leverage Medicare Cost Center information to collect utilization information based on existing mappings.	*(4) Utilization Information.* *(1) Review utilization information.*
Streamline reporting to minimum necessary additional material and leverage sources in the public domain (e.g., annual Continuing Disclosure Reports).	(7) *Other information the Board determines to be relevant to the Board's obligations under this section…*

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5. Confidentiality

- **Recommendation:** Proceed with drafting the Administrative Regulation to include a clear process for hospital submitters to identify information that should remain confidential.

- **Recommendation:** Proceed with drafting the Administrative Regulation to include clear protocols for the Diamond State Hospital Cost Review Board to partition and protect information that is deemed confidential per the process outlined above.

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Outstanding Topic Areas

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Summary of Outstanding Issues

Outstanding Issue	Recommendation
Definition of a hospital	Use the existing statutory definition of a hospital, including statutory limitations in the Board's purview: "Hospital" means as defined in § 1001 of this title, except that hospitals that exclusively provide psychiatric services, rehabilitative services, or long-term acute care services are excluded from the application of this subchapter.
Level of detail for utilization information	Leverage the cost centers defined by CMS to collect utilization information using the specified units of analysis.
Level of granularity for types of payers	Request more detail than available in the existing domain.
Simplify information gathering	To simplify burden, limit additional request to consolidating statements and mapping of AFS to standard categories.
IRS 990 information	Instead of requiring an additional filing, the Board can look at trends based on data in the public domain.
Access to care	The Board can review information in the public domain to assess access to care and its quality.

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Definition of a Hospital

§ 9951. “Hospital” means as defined in § 1001 of this title, except that hospitals that exclusively provide psychiatric services, rehabilitative services, or long-term acute care services are excluded from the application of this subchapter.

§ 1001 (a). …“hospital” means a health-care organization that has a governing body, an organized medical and professional staff, and inpatient facilities, and provides either medical diagnosis, treatment and care, nursing and related services for ill and injured patients, or rehabilitation services for the rehabilitation of ill, injured or disabled patients 24 hours per day, 7 days per week and primarily engaged in providing inpatient services.

The Administrative Rule can inherit these definitions, resulting in the current set of 6 “Regulated Hospitals:”

BAYHEALTH:

- Bayhealth Kent Campus (080004)
- Bayhealth Sussex Campus (080009)

BEEBE:

- Beebe Medical Center (080007)

CHRISTIANACARE:

- Christiana Hospital (080001)

(includes Wilmington Hospital (provider-based department under 42 CFR 413.65))

NEMOURS:

- Nemours Children's Hospital Delaware (083300)

TIDALHEALTH:

- Nanticoke Memorial Hospital (080006)

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Audited Financial Statements

Hospitals and related organizations can be complex. To reduce burden and leverage what is already available, consider two additional requirements:

1) If a hospital's AFS required *consolidating exhibits* that are *not already included in the AFS package*, hospitals should submit them as a supplement. (Note that review of previous years indicates these are largely already included in the AFSs already submitted).

2) Maintain standard mapping of the *consolidated* statement to a standard template. The Milbank Memorial Fund published a template with instructions to make this consistent across filers. (Note that this is mapping the existing AFS information and not "new" information.)

Here are examples from a consolidating balance sheet and statement of operations for the Luminis Health, Inc:

Assets	Luminis Health Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Luminis Health Clinical Enterprise, Inc. and Subsidiaries	Luminis Health Ventures, LLC and Subsidiaries	Eliminations	Consolidated
Current assets:							
Cash and cash equivalents	$ (5,499)	10,972	3,917	12,636	2,440	—	24,466
Short-term investments	—	539	—	—	—	—	539
Current portion of assets whose use is limited	—	3,297	1,604	—	19,208	—	24,109
Patient receivables	(500)	90,397	40,483	26,372	945	—	157,697
Inventories and supplies	68	9,099	3,717	1,309	—	—	14,193
Prepaid expenses and other current assets	7,551	14,797	7,701	1,915	1,315	—	33,279
Intercompany receivables/(payables)	(102,045)	152,474	(54,142)	(33,585)	37,298	—	—
Right-of-use assets – short term	—	—	129	—	—	—	129
Total current assets	(100,425)	281,575	3,409	8,647	61,206	—	254,412
Property and equipment	1,590	811,006	203,532	63,713	149,756	—	1,229,597
Less accumulated depreciation and amortization	143	(489,151)	(52,353)	(47,891)	(79,390)	—	(668,642)
Net property and equipment	1,733	321,855	151,179	15,822	70,366	—	560,955

	Luminis Health Inc.	Luminis Health Anne Arundel Medical Center, Inc. and Subsidiaries	Luminis Health Doctors Community Medical Center, Inc. and Subsidiaries	Luminis Health Clinical Enterprise, Inc. and Subsidiaries	Luminis Health Ventures, LLC and Subsidiaries	Eliminations	Consolidated
Operating revenue:							
Net patient service revenue	$ —	708,434	274,785	257,861	6,980		1,248,060
Other operating revenue	(1)	52,047	5,067	63,096	38,165	(82,241)	76,133
Total operating revenue	(1)	760,481	279,852	320,957	45,145	(82,241)	1,324,193
Operating expenses:							
Salaries and wages	62,148	236,189	102,548	203,135	1,579	—	605,599
Employee benefits	10,279	43,385	17,300	23,372	311	—	94,647
Supplies	1,301	130,036	37,772	52,963	256	—	222,328
Purchased services	89,432	139,779	69,312	63,869	31,928	(81,301)	313,019
Foundation transfer	—	660	280	—	—	(940)	—
Depreciation and amortization	6	21,084	18,789	3,217	3,766	—	46,862
Interest	26	10,463	3,512	—	2,555	—	16,556
Shared services	(163,192)	126,256	36,936	—	—	—	—
Total operating expenses	—	707,852	286,449	346,556	40,395	(82,241)	1,299,011
Operating income (loss)	(1)	52,629	(6,597)	(25,599)	4,750	—	25,182

Source: Maryland Health Service Cost Review Commission

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Utilization Granularity

Medicare Cost reports include 99 “cost centers” or departments to track revenue and, when pertinent, utilization:

Cost Center Area	#	Description
General Service	23	Overhead departments that support the whole hospital but don't directly treat patients (e.g., utilities, housekeeping, Graduate Medical Education)
Inpatient Routine	13	Room and board by unit type (e.g., medical/surgical, rehab)
Ancillary	29	Departments that bill separately from room and board (e.g., radiology, lab)
Outpatient	7	Visit-based services (e.g., clinic, ED)
Other Reimbursable	9	Reimbursable services outside the main structure (e.g., ambulance, durable medical equipment)
Special Purpose	13	Organ acquisition programs and other carved-out cost pools (e.g., hospice)
Nonreimbursable	5	Costs Medicare explicitly excludes (e.g., gift shop, research, physicians' private offices)
Total	**99**	

Here is an example of how Medicare collects this information based on Worksheet S-3, Part I:

PART I - STATISTICAL DATA

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Inpatient Days / Outpatient Visits / Trips: Title V	Title XVIII	Title XIX	Total All Patients
		1	2	3	4	5	6	7	8
1	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)								
2	HMO and other (see instructions)								
3	HMO IPF Subprovider								
4	HMO IRF Subprovider								
5	Hospital Adults & Peds. Swing Bed SNF								
6	Hospital Adults & Peds. Swing Bed NF								
7	Total Adults and Peds. (exclude observation beds) (see instructions)								

Full Time Equivalents: Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Discharges: Title V	Title XVIII	Title XIX	Total All Patients	
9	10	11	12	13	14	15	
							1
							2
							3
							4
							5
							6
							7

Source: Cost Report Data

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Payer Granularity

Medicare Cost reports break revenue out into a few categories for statistical reporting:

1) Traditional Medicare

2) Medicaid

3) Title V (Children with Special Health Care Needs)

4) All Patients (Total across all payers)

This does not provide detail into commercial health insurance plans and makes it difficult to distinguish between traditional and managed care for Medicare and Medicaid programs. This may limit the ability of the Board to assess subpopulations of interest, such as the commercially insured.

Here is an example from how California handles this:

Line No.	PATIENT REVENUE PRODUCING CENTERS Revenue Subclassifications	Account No.	MEDICARE Traditional (1) Gross Inpatient Revenue .04	 (2) Gross Outpatient Revenue .44	Managed Care (3) Gross Inpatient Revenue .14	 (4) Gross Outpatient Revenue .54	Line No.
	DAILY HOSPITAL SERVICES						
5	Medical/Surgical Intensive Care	3010	$		$		5
10	Coronary Care	3030					10
15	Pediatric Intensive Care	3050					15
20	Neonatal Intensive Care	3070					20
25	Psychiatric Intensive (Isolation) Care	3090					25
30	Burn Care	3110					30
380	Electroconvulsive Therapy	4820					380
385	Psychiatric/Psychological Testing	4830					385
390	Psychiatric Individual/Group Therapy	4840					390
395	Organ Acquisition	4860					395
400	Other Ancillary Services	4870					400
405	TOTAL ANCILLARY SERVICES		$	$	$	$	405
415	TOTAL PATIENT REVENUE		$	$	$	$	415

Line No.	Revenue Subclassifications	Account No.	MEDICARE Traditional Inpatient	 Outpatient	MEDICARE Managed Care Total		Line No.
	DEDUCTIONS FROM REVENUE						
420	Provision for Bad Debts		$	$	$		420
425	Contractual Adjustments (exclude capitation revenue)						425
426	Disproportionate share payments for Medi-Cal patient days (SB 855) (Credit Balance)						426
430	Charity						430
435	Restricted Donations and Subsidies for Indigent Care (Credit Balance)						435
440	Teaching Allowances						440
445	Support for Clinical Teaching (Credit Balance)						445
450	Other Deductions						450
455	TOTAL DEDUCTIONS FROM REVENUE		$	$	$		455
457	CAPITATION PREMIUM REVENUE				$		457
460	NET PATIENT REVENUE (line 415 - 455 + 457)		$	$	$		460

Source: California Department of Health Care Access and Information

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IRS 990

The IRS requires reporting of compensation for a specific set of individuals for non-profit hospitals:

Schedule	Category	Threshold
Part VII-A	Current officers, directors, trustees	n/a (reported for all)
Part VII-A	Current key employees	>$150,000 AND manages/controls 10%+ of org activities, assets, income, expenses, capital expenditures, operating budget, or employee compensation (limited to top 20)
Part VII-A	Current 5 highest compensated employees (not already listed above)	>$100,000
Part VII-A	Former officers, key employees	>$100,000
Part VII-A	Former directors, trustees	>$10,000 for services in former capacity
Part VII-B	5 highest compensated independent contractors	>$100,000
Schedule J	Current officers, directors, trustees, key employees, 5 highest comp	Cols D+E+F total >$150,000
Schedule J	All formers listed in Part VII-A	n/a (reported for all)

These reports are publicly available from the IRS, as well as more user-friendly summaries. Example from Yale New Haven Hospital:

Compensation

Key Employees and Officers	Compensation	Related	Other
Marna Borgstrom (Former Officer)	$3,123,075	$2,154,050	$0
Cynthia Sparer (Evp)	$987,135	$0	$48,034
Michael Holmes (Evp/Coo (Vested Deferred))	$937,596	$0	$0

(A) Name and Title		(B) Breakdown of W-2, 1099-MISC compensation, and/or 1099-NEC		
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation
1 MARNA BORGSTROM FORMER OFFICER	(i)	0	0	3,123,075
	(ii)	0	0	2,154,050

(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
0	0	3,123,075	2,123,250
0	0	2,154,050	0

Source: ProPublica Nonprofit Explorer

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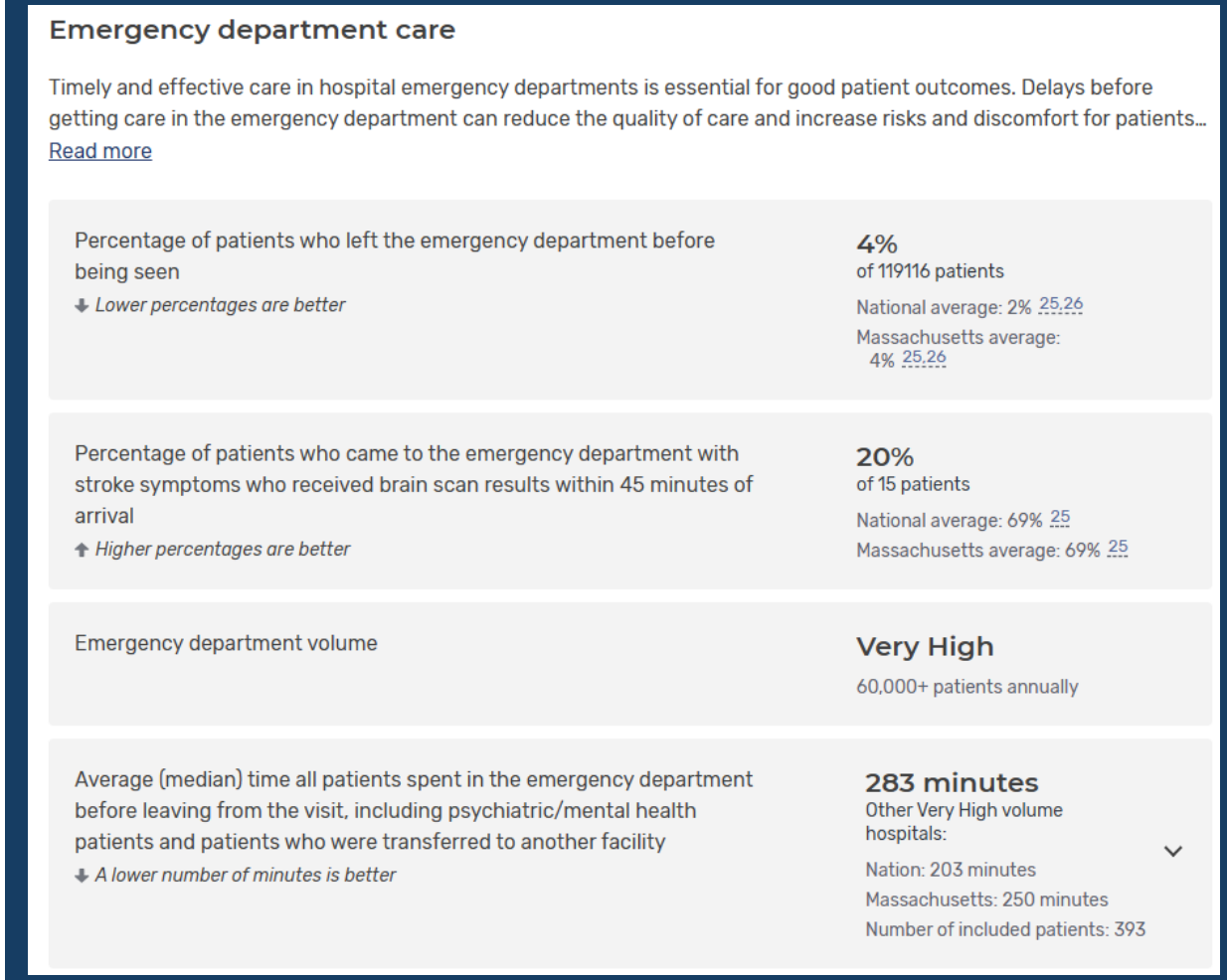
Access to Care

There are many data sources in the public domain that describe access to care, as well as quality, which could provide valuable context. Resources include:

Program	Source	Category / What's Reported
Care Compare	CMS	Mortality, readmissions, Healthcare-Associated Infections, Hospital Consumer Assessment of Healthcare Providers and Systems, staffing, value program results
Star Ratings	CMS	Composite score (1–5 stars)
Joint Commission	Joint Commission	Accreditation status
DNV	DNV	Accreditation status
Leapfrog	Leapfrog Group	Safety grades, ICU staffing, Computerized Physician Order Entry, surgical volumes
Lown Institute	Lown Institute	Social responsibility — value, equity, overuse avoidance
State Health Data Center	The Commonwealth Fund	Aggregates state assessment of access, quality, cost, and outcomes.

Here is an example from CMS Care Compare for Massachusetts General Hospital:



Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before getting care in the emergency department can reduce the quality of care and increase risks and discomfort for patients...
Read more

Percentage of patients who left the emergency department before being seen
Lower percentages are better
4%
of 119116 patients
National average: 2% 25,26
Massachusetts average: 4% 25,26

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival
Higher percentages are better
20%
of 15 patients
National average: 69% 25
Massachusetts average: 69% 25

Emergency department volume
Very High
60,000+ patients annually

Average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility
A lower number of minutes is better
283 minutes
Other Very High volume hospitals:
Nation: 203 minutes
Massachusetts: 250 minutes
Number of included patients: 393

Source: CMS

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Summary of Planned Submission

Exhibit	Description (Authority)	Additional burden
Audited Financial Statements (AFSs)	Financial reports that have been reviewed and verified by an independent agency (§9953(b)).	**LOW:** Request consolidating exhibits if prepared but not included in the reporting package.
AFS template	Provides an apples-to-apples summary of the AFS at the consolidated level (Ibid. and §9952(g)).	**MEDIUM:** Requires categorization of AFS to common categories.
Hospital price transparency files	Provides CMS-defined price transparency data in an approved, machine-readable format per 45 CFR Part 180 (§9953(a)(5)).	**NONE:** Already prepared for CMS
Utilization information	Breaks Medicare Cost Report utilization and gross patient revenue into more granular payer types (§9953(a)(4) and (d)(1)).	**MEDIUM-HIGH:** Requires breaking out non-governmental revenue into more refined categories. Burden depends on existing systems.
Workforce investment	Provides specific focus on workforce development initiatives to allow Board's review (§9953 (d)(4)).	**LOW-MEDIUM:** Requires additional elements not currently reported. Burden depends on existing systems.

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Outstanding Issue and Discussion of Timing

The following written comment was provided by ChristianaCare on April 25, 2026:

> With respect to statutory intent, information submitted by hospitals to the Board is for the purpose of assessing compliance against the spending benchmark. Hospitals are assessed against the benchmark starting in 2027. To that end, pre-2027 information is inconsistent with the statutory intent because the benchmark, as applied to hospitals by the Board, will not yet be operational. Notably, the year for benchmark compliance was originally established as 2026. However, SB 213, signed into law in January 2026, revised the compliance year from 2026 to 2027. If the General Assembly had intended reporting to begin in 2026, it would have left the original compliance year unchanged. Instead, the General Assembly proactively revised the compliance year to 2027.

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Thank you.

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