Diamond State Hospital Cost Review Board Meeting:

Draft Administrative Regulation Discussion

June 9, 2026

Meeting Agenda

Agenda Item	Time
Welcome	10:00 AM – 10:05 AM
SB1 Update	10:05 AM – 10:10 AM
Review and Discussion of Plain-Language Administrative Regulation Sections	10:10 AM – 12:00 PM
Forthcoming Board Meeting Topics and Work	12:00 PM – 12:15 PM
Next Steps & Close	12:15 PM – 12:30 PM

SB1 Update

SB 1 Overview and Update

Senate Substitute 2 for Senate Bill 1 of 2026 passed the Delaware Senate unanimously on May 19, 2026.

The bill pursues three goals:

1. Expand primary care investment by maintaining the requirement that insurers devote at least 11.5% of total health care spending to primary care, with 5% delivered as prospective payments, and extending the obligation to the State Employee Health Plan, and Medicaid.

2. Control health care spending through hospital referenced-based pricing tied to Medicare rates.

3. Accelerate value-based care adoption statewide by requiring commercial insurance carriers to meet minimum Alternative Payment Model contracting thresholds.

SB 1 Overview and Update

Hospital Reference-Based Pricing

The bill caps what the fully insured market and the State Employee Health Plan can pay hospitals as a percentage of the full Medicare rate (wage-adjusted and inclusive of any applicable adjustments).

Commercial Fully Insured Market ~89,000			
Rate Filing Year	Plan Year	Outpatient Rates	Inpatient and ED Rates
2028-2029	2029-2030	275% of Medicare	310% of Medicare
2030-2031	2031-2032	250% of Medicare	275% of Medicare
2032+	2033+	250% of Medicare	250% of Medicare

State Employee Health Plan ~125,000		
Plan Year	Outpatient Rates	Inpatient and ED Rates
2030-2031	275% of Medicare	310% of Medicare
2032-2033	250% of Medicare	275% of Medicare
2034+	250% of Medicare	250% of Medicare

SS 2 for SB 1 Overview and Update

Potential Interactions with Diamond State Hospital Cost Review Board

1. The bill extends the existing Consumer Price Index (CPI)-based aggregate unit price growth cap for non-professional services to rate filings in 2027; the Board is required to review hospital financial information relative to the annual rate filing cost containment requirements under § 2503 of Title 18.
    1. The bill exempts the following hospital types from the extended 2027 CPI cap: Free-Standing Children's Hospitals, Medicare-Dependent Rural Hospitals (Type 1) and Urban Medicaid DSH Hospitals.

2. The Board's Plain Language Draft Administrative Regulation proposes that hospitals report revenue by payer category, specifically including commercial insurance; this level of reporting will enable the Board to capture the impact of commercial prices that are tied to Medicare rates as a reference point.

3. The Board's future work to determine Meaningful Cost Containment Arrangement parameters may consider Alternative Payment Models that meet the definition of Health Care Learning and Action Network (HCP-LAN) Category 3 or Category 4, as specified in SS 2 for SB 1.

Review and Discussion of Plain-Language Administrative Regulation

1. Process and Engagement: Draft Administrative Regulation

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	Written Feedback May 15, 2026
• ChristianaCare • Beebe Healthcare • Nemours • BayHealth • TidalHealth • Trinity Health/St. Francis Hospital • Delaware Hospital Association	• Delaware Healthcare Association • ChristianaCare	• ChristianaCare • Beebe Healthcare • Nemours • BayHealth • TidalHealth • Trinity Health/St. Francis Hospital • Delaware Healthcare Association	• Delaware Healthcare Association • Nemours	• Delaware Healthcare Association

Summary of Key Issues

1.	**Process and engagement:** In April, DHA and ChristianaCare requested additional engagement before finalizing the URM. In written comments on May 15, DHA requested a third working session with hospitals.	An additional hospital working session was held on April 27.
2.	**Submission schedule for annual review:** Hospitals indicated the submission schedule as initially proposed was too compressed and must account for differing fiscal years.	Schedule adjusted to allow time for Boards of Managers to approve audited financials; calendar-year hospitals submit on same schedule with lagged data.
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 leveraging existing submissions rather than a separate template.	Draft administrative regulation and URM narrowed to focus on elements that align with Medicare Cost Reports and audited financial statements.
4.	**Scope:** Questions raised about whether some URM elements fall out of scope — particularly revenues and expenses from affiliated entities, system-level operations, and access-to-care metrics.	Draft reporting requirements no longer include access-to-care metrics available in the public domain.
5.	**Confidentiality:** DHA and ChristianaCare emphasized that safeguards must be in place to protect proprietary information.	Confidentiality is proposed as a standalone section of the administrative regulation.

Administrative Regulation: Plain Language Draft Summary of Pertinent Sections

Draft Regulation Section	Purpose
3.0 Definitions	Lays out the key terms used through the regulation.
5.0 Submission of Hospital Information	Establishes the annual schedule for hospitals to submit financial and utilization information to the Board and indicates the submission contents.
6.0 Uniform Reporting Manual	Establishes the standard definitions, formats, and submission requirements for the financial and utilization data that hospitals report to the Board.
7.0 Standard for Review	Communicates how the Board will assess financial information.
8.0 Hospital Narrative	Provides the expectations for narrative submission to accompany financial and utilization information.
9.0 Review of Publicly Available Data	Establishes that the Board will review publicly available data in its annual assessment.
10.0 Disclosure and Public Hearings	Establishes that the Board will publish hospital information within 30 days of receipt; provides for public hearings and comment.
11.0 Confidentiality and Privacy	Procedures for a hospital to request confidential treatment of information.
12.0 Extension Requests	Lays out the conditions under which a hospital may seek extension of the time to submit required financial information.

Section 3.0: Definitions

“Audited Financial Statements” means the complete set of financial documents prepared by a Hospital and examined by an independent auditor, consisting of: (a) the independent auditor’s report (opinion letter); (b) consolidated financial statements, including the balance sheet, statement of operations, statement of changes in net assets, statement of cash flows, and accompanying notes; and (c) supplemental consolidating schedules and accompanying notes.

“Day” calculations: calculated from the from the date of Hospital information submission to the Board. Where a deadline falls on a Saturday, Sunday, or State holiday, the deadline is extended to the next business day.

“Hospital” means a hospital as that term is defined in 16 Del. C. §§ 9951.

“Hospital information” means hospital financial and utilization information and data.

“Spending benchmark” means the spending benchmark as that term is defined in 16 Del.C. § 9903.

“State” means the State of Delaware.

“Uniform Reporting Manual” or “Manual” means the technical specification for hospital information set forth in Section 6.0 of this regulation.

Section 5: Submission of Hospital Information

Timing

- Annually on January 31st, hospital information for the most recently completed fiscal year, for which Audited Financial Statements have been finalized, shall be submitted to the Board.
- Upon submission, the Board will review submissions and may direct questions to the hospitals for a period of no fewer than 30 days.
- A hospital shall present about the contents of its submission and engage in dialogue with the Board no fewer than 60 days following the date of the hospital's submission.
- The Board shall complete its final review and issue findings of fact and determinations no fewer than 90 days following the submission of hospital information.

This schedule provides for hospital information submission to occur 200 days from the Fiscal Year End for hospitals operating on a July-June FY and provides 380+ days to prepare hospital financial information for submission when hospitals are operating on a calendar-year.

Section 5: Submission of Hospital Information

Contents

- Audited Financial Statements

- Hospital information as set forth in the Uniform Reporting Manual (Section 6) redlined to reflect increases and changes from the fiscal year immediately preceding such fiscal year.

Section 5: Audited Financial Statement (AFS)

AUTHORITY
16 Del. C. § 9953(a)

- In accordance with Board feedback, hospitals are expected to submit AFSs each year by **January 31st**. This means that hospitals will not be submitting information for the same fiscal year.

- For example, submissions expected by **February 1, 2027** (January 31st is a Sunday):

	Submission fiscal year
FY2025	January 1, 2025 – December 31, 2025
FY2026	July 1, 2025 – June 30, 2026

AFS Submission Components (1 of 3)

Component		Description
Report of Independent Auditors (opinion letter)		Independent auditor's written conclusion on whether the AFS present fairly, in all material respects, the financial position and results of operations in accordance with U.S. generally accepted accounting principles (GAAP). Issued as – unmodified ("clean"), qualified, adverse, or disclaimer.
Consolidated Financial Statements	Financial Position	A snapshot of the Hospital's assets, liabilities, and net assets as of the fiscal year-end date.
	Operations	Operating and non-operating revenues, expenses, gains, and losses for the fiscal year, presenting the excess or deficiency of revenues over expenses.
	Changes in Net Assets	Changes with or without donor restrictions during the fiscal year.
	Cash Flows	Cash inflows and outflows during the fiscal year classified into operating, investing, and financing activities, reconciling beginning and ending cash and cash equivalents.
	Notes	Disclosures supplementing the four primary statements required by GAAP.

AFS Submission Components (2 of 3)

Component		Description
Supplementary consolidating information	Supplemental Consolidating Schedules	Provide disaggregation of consolidated statements by subsidiary or reporting entity, showing each entity's contributions, along with the intercompany eliminations applied.
	Accompanying Notes to Consolidating Schedules	Disclosures specific to the consolidating presentation, including the basis of consolidation, eliminations methodology, and entity-level matters not visible in the consolidated statements.
	Independent Auditor's Report on Supplemental Information	The auditor's report addressing whether the supplemental consolidating schedules are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

AFS Submission Components (3 of 3)

These components would include material typically not distributed publicly, which may result in Confidentiality Requests unless explicitly carved out in the Administrative Rule.

Component		Description
Management letter and other auditor communication	Management letter	Auditor communications addressing observations, recommendations, and findings regarding internal controls, accounting policies, or operational matters that are not required to be reported under applicable auditing standards. Issued at the auditor's discretion.
	Required communications	Auditor communications to those charged with governance and to management required under applicable auditing standards, including communications regarding audit scope, significant findings, accounting policies, management judgments, audit adjustments, uncorrected misstatements, and any material weaknesses or significant deficiencies in internal control over financial reporting. If the audit is performed under Government Auditing Standards or the Hospital is subject to a Single Audit under the Uniform Guidance, the auditor's reports on internal control and on compliance issued in connection therewith.

Hospitals and Other Entities

	Hospitals	Other consolidated entities
Bayhealth	**No consolidating schedules included for FY2024**	
Beebe	**Beebe Medical Center**	Delmarva Health Network; Beebe Medical Group; Beebe Medical Foundation
Christiana Care (CC)	**CC Health Services**	CC Health Systems; Union Hospital; CC Health Initiatives; CC Health Plans; CC Gene Editing Institute; Leeward Health; CC Strategic Investments
Nemours	**Nemours Children's Hospital, Delaware**	The Nemours Foundation; Nemours Children's Clinics; Nemours Senior Care; Nemours Value Based Services Organization; Nemours Children's Hospital, FL
TidalHealth (TH)	**TH Nanticoke**	TH; TH Peninsula Region; Combined TH Medical Partners; McCready Foundation; Peninsula Health Ventures; TH Surgery Center, Peninsula Region Clinically Integrated Network; TH Foundation; Delmarva Peninsula Insurance Company
Trinity Health Mid-Atlantic	**St. Francis Hospital**	Mercy Catholic Medical Center; Nazareth Hospital; Mercy Accountable Care; Mercy Accountable Care MSSP; St. Agnes Continuing Care; Mercy Management Combined Physicians; Nazareth Physician Services; Mercy Home Health Services; Mercy Eastwick; Mercy Health System Foundation; Mid-Atlantic Home Office; St. Mary Medical Center; Quality Health Alliance, MSSP; Quality Health Alliance; Ambulatory Surgery Center; St. Mary's Rehabilitation Hospital; Life St. Mary; St. Mary Emergency Medical Services; Trinity Health Mid-Atlantic Medical Group; St. Mary Building and Development; St. Francis EMS; DE Care Collab, MSSP; LIFE at St. Francis

Delaware Hospital Share of Consolidated AFSs (FY24)

Section 6: Uniform Reporting Manual (URM)

Reporting frameworks	Establishes financial reporting principles
Supplementary filings	Requirements for price transparency files and consolidating schedules (if prepared, but not already included in AFS)
Revenue and cost concepts	Defines revenue categories
Payer categories	Expected categorization of revenue by source of payment
Cost center and utilization concepts	References expected cost centers and units of utilization
Reconciliation concepts	Standard categories of expenses not captures in patient revenue centers
Standardized AFS concepts	Guidance on mapping consolidated AFSs to standardized format
Workforce development concepts	Classification and impact of workforce development investments

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a)

- Incorporates by reference:
  - United States generally accepted accounting principles (GAAP) as established through the Financial Accounting Standards Board's Accounting Standards Codification (FASB's ASC).
  - Medicare Cost Report's Centers of Medicare & Medicaid Services' (CMS's) Form 2552-10 and related guidance.
- Establishes the reporting period as a 12-month fiscal year (FY), unless otherwise specified by the DSHCRB

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a), (b)

- Specifies the format for the Hospital Price Transparency Files, required under 45 C.F.R. § 180 to ensure it can be processed in a consistent format (as of the hospital's fiscal year end).

- Specifies that, if consolidating schedules are produced in preparation of a hospital's AFS and not already included, they will be included as a supplement to the statutorily-required AFS.

Section 6: Reporting Frameworks

- Provides categories for classifying revenue, such as:
  - Allowances and discounts
    - Contractual adjustments
    - Charity care / financial assistance
    - Bad debt
    - Implicit price concessions
    - Other uncompensated care
  - Other operating revenue
  - Disproportionate Share Hospital (DSH) payments
  - Graduate Medical Education (GME) payments

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a)

- Breakouts for gross patient revenue and utilization by cost center type (e.g., inpatient routine, ancillary) and *total* net patient revenue:
  - Medicare (original / fee-for-service)
  - Medicare Advantage
  - Medicaid (fee-for-service)
  - Medicaid managed care
  - Employee Health Plan
  - Other commercial insurance
  - Self-pay
  - Other (e.g., Worker's compensation)

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a)

- Reporting frameworks
- Supplementary filings
- Revenue and cost concepts
- Payer categories
- **Cost center and utilization**
- Reconciliation concepts
- Standardized AFS concepts
- Workforce development

- Expectations for how to categorize cost centers and units of utilization (i.e., per Medicare Cost Reports).
- All-Patient Case Mix Index, using hospital's preferred grouper (e.g., MS-DRG, APR-DRG).

Utilization information will be collected at the **CCN level**

Medicare uses a unique, 6-digit identification number to organize healthcare facilities, known as the CMS Certification Number (CCN).

The first 2 digits identify the state code (08 for Delaware) and the remaining 4 represent the type of hospital. The regulation currently applies to short-term general hospitals and children's hospitals in the CMS framework.

CCNs for Regulated Hospitals:

- **BAYHEALTH**
  - 080004 = Kent
  - 080009 = Sussex
- **BEEBE**: 08007
- **CHRISTIANACARE**: 08001 (*includes both campuses*)
- **NEMOURS**: 083300
- **ST. FRANCIS (TRINITY)**: 080003
- **TIDALHEALTH NANTICOKE**: 08006

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a)

- Sets out categories for charges and revenues not recognized on Medicare Cost Reports:
  - Non-reimbursable Clinical and Research Activity
  - Non-patient revenue (e.g., rental income)

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(a), (b)

- Provides “apples-to-apples” categorization of consolidated AFSs:
  - Statements of operations
  - Balance sheet inputs
  - Statement of cash flows inputs
  - Notes inputs

Section 6: Reporting Frameworks

AUTHORITY

16 Del. C. § 9952(g)
16 Del. C. § 9953(d)(4)

- Standard reporting of investments and individuals participating in such initiatives:
  - Clinical education and training
  - Apprenticeship and pipeline programs
  - Tuition assistance and loan repayment
  - Other

Section 7: Standard for Review

- On an annual basis, the Board will evaluate each hospital's financial performance between the most recently completed fiscal year and the immediately preceding fiscal year to determine whether a hospital has satisfied the State's Health-care spending policy directives.

Section 8: Hospital Narrative Submission

- Each hospital is required to submit a written narrative to the Board.
- The narrative should outline year-over-year changes and the actions the hospital has taken and will take to adhere to the benchmark.
- The narrative should identify whether there has been a material change in the proportion of executive and clinical leadership compensation to total operating expenses compared to the prior year.
- If a material change has occurred, the hospital shall explain the reasons.
- “Material change” means year-over-year change of 1.0% or more in the ration of clinical and executive compensation to operating expenses, or 1.0% or more change in total executive compensation.

AUTHORITY
16 Del. C. § 9953(a)(6)
16 Del. C. § 9953(d)(5)

This narrative requirement enables the Board to rely on Internal Revenue Service Form 990 Schedule J reporting to inform its understanding of clinical and executive leadership compensation for each Delaware hospital, consistent with its authority, and to understand changes that impact year-over-year performance at a hospital prior to these changes being reflected in Schedule J.

Section 9: Review of Publicly Available Data

The Board shall review the following publicly available data:

- Internal Revenue Service Form 990 filed by each hospital.
- Cost reports from the Centers for Medicare and Medicaid Services Healthcare Provider Cost Reporting Information System.
- Quality and patient experience data for each hospital, including data published through the Centers for Medicare and Medicaid Services Care Compare platform at medicare.gov and the CMS Provider Data Catalog at data.cms.gov.
- Quality and patient experience data provides contextual information for the Board's benchmark compliance determinations and any policy recommendations issued pursuant to 16 Del.C. § 9951 *et seq*.

AUTHORITY
16 Del. C. § 9953(a)(7)

This section limits hospital submission requirements to information not already publicly available in a practical format, which the Board will access directly.

Section 10: Disclosure and Public Hearings

- Hospital information will be posted on the Board's website within 30 days of submission of information, unless identified as confidential by hospital submitters and deemed confidential per the Board's process.

- The Board shall schedule public hearings no later than 120 days after the submission of information for each hospital.

- The public hearings shall constitute a "meeting" with the hospital; the Board or hospital may request to have additional private meetings only if the information to be discussed has been deemed confidential.

AUTHORITY
16 Del.C. § 9958(b)(2)
16 Del.C. § 9958(c)
16 Del.C. § 9958(d)(3)

Section 11: Confidentiality and Privacy

- The following are public records per 16 Del. C. 9958 (b) (2) and shall be posted on the Board's or the Commission's website:
  a. Original and modified budgets
  b. Spending and revenue data
  c. Utilization information

- A hospital seeking confidential treatment for any other information shall submit, contemporaneously, with its filing: written Confidentiality Request and a redacted public version.

- Confidential treatment may be sought only for:
  a. Trade secrets
  b. Commercial or financial information whose disclosure would cause substantial competitive harm
  c. Information whose disclosure is expressly prohibited by federal law

- The Board shall issue a written determination within thirty (30) days of a complete Confidentiality Request and prior to making the requested information public should the request be denied.

This section answers stakeholder feedback by establishing procedures for protecting commercially sensitive information from public disclosure where release would cause competitive harm to a submitting hospital.

Section 12: Requesting Extension for Submitting Financial Information

- A hospital may request an extension of time to submit required financial information when circumstances outside of the Hospital's reasonable control impair its ability to comply with the submission deadline.

- Such circumstances include natural disasters, public health emergencies, cyber security incidents or other external factors determined by the Board to constitute good cause.

- The request must be submitted in writing, and the Board may grant, deny, or conditionally grant an extension upon finding good cause; the Board will make its determination in writing.

Forthcoming Board Meeting Topics and Work

Upcoming Board Meeting Topics

Board Meeting	Topics
July 21, 2026	• Vote on Draft Administrative Regulation • Orientation to currently available data to describe Delaware hospitals • Preparation for Delaware Health Care Commission presentation
August 26, 2026	• Delaware Health Care Commission Presentation
September 23, 2026	• Benchmark Compliance Plan Criteria • Meaningful Cost Containment Arrangements

Public Comment

Next Steps & Close

Thank you.

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