



June 16, 2025

U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Submitted electronically at www.regulations.gov

Re: CMS-0042-NC; Response to Health Technology Ecosystem Request for Information

To Whom It May Concern,

Delaware Health Information Network (“DHIN”) is a statutory instrumentality of the State of Delaware that operates as the state-approved provider of health information exchange services and the operator of the State of Delaware’s Healthcare Claims Database. In fulfilling those dual mandates, DHIN serves Delaware and surrounding states, playing a critical role in the accurate and timely sharing of health data needed to improve care and ensure positive outcomes for patients.

DHIN welcomes the opportunity to respond to the May 16, 2025 Request for Information: Health Technology Ecosystem (CMS-0042-NC) issued by the Centers for Medicare & Medicaid Services (“CMS”), the Assistant Secretary for Technology Policy (“ASTP”)/Office of the National Coordinator for Health Information Technology (“ONC” and, with ASTP, “ASTP/ONC”), and the United States Department of Health and Human Services (“HHS”) (the “Health Technology Ecosystem RFI”).¹

DHIN is providing these comments not only as a state-authorized Health Information Exchange (“HIE”) with a long-standing mission to promote interoperability within our state and the surrounding region, but also as an organization that has significant experience working to operationalize and simplify the process by which individuals and their care professionals are able to access and use their health data. DHIN actively works to drive this process both directly through DHIN and through third party technology vendors and significant stakeholders such as value-based care organizations. The federal government has made significant investments in DHIN and organizations like it, and there is a current and actionable opportunity for the federal government to leverage HIEs and the work that has already been done to meet the goals of

¹ Capitalized terms not otherwise defined have the meaning ascribed to them in the Health Technology Ecosystem RFI.



easier patient access to healthcare data and meaningful interoperability in a direct and cost-efficient manner. By providing targeted and designated funding and grant opportunities to States to either continue to build out or (in the case of established HIEs like DHIN), increase utilization of their state and regional HIEs, the federal government could prevent duplication of efforts, help eliminate data silos and system fragmentation, increase the accuracy and availability of data for reporting to federal and state agencies, and ultimately spur innovation and the economy while bringing down the costs of care for millions of Americans.

DHIN's responses to specific questions in the Health Technology Ecosystem RFI are as follows:

PC-11: How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world?

HIEs have made extraordinary inroads in connecting disparate systems and technologies, and provide a vital connection in particular to the facilities in the "last mile of care" – the individual primary care offices that are simultaneously the most important providers in terms of their ability to influence patient health outcomes and the least well equipped to address evolving and cost-driving needs as they relate to interoperability and health data technology. HIEs also serve a vital role in the data normalization process. Even with standards set at the federal level, there is still wide variation in both adoption and adherence to published standards that an entity with direct knowledge of the particular service provider and the needs for which the data will be utilized (all of which vary across state and regional boundaries) is required to work through and provide long-term care and support.

HIEs fill this role and fill it well. Given their geographic relevance, they can work directly with specific individuals at providers and other data sending organizations and can help meet a wide variety of needs with respect to levels of technological sophistication. They also can curate, normalize, and provide access to this data directly where it is needed for any permissible use case, including reporting to state and federal agencies, treatment at other systems, benchmarking for value-based care payment contracts, and providing the "on-ramp" (both technologically and with respect to data quality) for data sharing initiatives like TECCA.

PC-11(a): How valuable, available, and accurate do you find the data they share to be?

DHIN is a state-authorized HIE with wide adoption across both the State of Delaware and its surrounding areas. DHIN has been receiving and normalizing data across a variety of data sources for nearly 15 years and is able to provide significant and consistent data to its recipients when and where that data is needed.



There remain challenges to this process, however. DHIN has long offered a free patient portal to individuals so that they can access any information in DHIN's possession. The goal of this process is to provide individual patients with a curated, longitudinal record of their care at DHIN-participating facilities. While much of the data is collected and provided, challenges with identity matching across multiple provider and data sources, standardizing data across data sources to present patients with trends (such as HgA1c trending), and gaps in coverage due to the high costs that EMRs impose on ambulatory and post-acute facilities that would otherwise participate in the data sharing process means that improvements can still be made.

At the federal level, these improvements could be facilitated by investments that encourage participation in regional and state-wide HIEs (that could offset some of the costs associated with interoperability), and that could unlock other cost savings for smaller and stand-alone facilities in particular by simplifying their reporting processes. Encouraging states and federal agencies to utilize HIEs as the preferred data source for public health and other reporting can also improve data quality while lowering costs. And while the wide-ranging and broad types of information captured by HIEs means that data normalization will always be a significant part of the value that HIEs add to the ecosystem, encouraging continued standardization can make that process easier and less burdensome on all parties involved.

PC-11(c): Are there particular examples of high-performing HIE models that you believe should be propagated across markets?

In DHIN's experience, the best way to unlock value for the health technology ecosystem and avoid wasting the significant investments that states and the federal government have made in this area is to encourage widespread adoption and use of not-for-profit HIEs with state-wide or significant regional coverage to collect, curate, and normalize both clinical and claims data to drive insights and developments. DHIN is one example of such an organization; there are many others that can be leveraged to meet the goals of the Administration in a cost-effective and streamlined manner.

Not-for-profit status is important for a number of reasons. For-profit entities that lack a dedicated mission are often constrained in their duty to shareholders in ways that hinder the long-term approach that is needed to keep data flowing and available. Collecting and dispersing data across a wide variety of systems and technologies (DHIN, for example, currently directly interfaces with over 30 EMRs, along with different agency reporting systems) is time consuming and low margin work that not-for-profits are uniquely equipped to engage in due to their mission to drive down ecosystem-level costs. Organizations like DHIN are able to work



directly with the last mile of care providers – who often do not have dedicated technology staff or significant time to focus on technology changes – over time to make sure that data is being reported in a normalized fashion and in a way that is useful for other data recipients. The time-horizons and profit motives of other organizations can get in the way of this type of incremental improvement.

This status also assists with patient concerns about privacy and confidentiality of health data. Unfettered access to data – especially sensitive data like health information – is a significant concern of many patients and ensuring that missional organizations like not-for-profits are directly involved in the collection and dissemination of that data for legally-compliant purposes helps resolve those concerns and encourage active participation. Patients respond well to having the ability to choose the data that they share and how they share it, and HIEs are well positioned to help address those desires directly.

The ability to combine and drive insights from not only clinical data – but also claims data from payer organizations – is also an important component of current success and future development. Having that information in a single organization streamlines access and allows for insights into cost, quality, and efficacy that are impossible – or at least made much more difficult – without the ability directly to combine clinical and claims information.

Geographic relevance is also important. Like DHIN, most HIEs have evolved organically in their respective markets, and have optimized their use cases and data quality processes for those markets. Having a geographically relevant, not-for-profit organization committed to interoperability and long-term improvement can help provide a trusted, neutral stakeholder to be a single repository for clinical, claims, and other related data that eliminates data silos and avoids duplication of costs and efforts.

This type of model – a geographically-relevant not-for-profit organization that can house (at least) both claims and clinical data – is most well equipped to build on the years of funding and progress that have already been invested, complete the hard work of connecting provider locations both large and small and provide actionable and accurate data to patients, providers, and regulatory authorities alike.

The federal government can encourage development by encouraging continued use and access to HIEs that follow this general framework, encouraging HIEs to be the source of reporting or mechanism of reporting to state regulatory authorities and federal agencies like CMS and CDC, and by providing guidelines on future funding initiatives that requires states and other



organizations to utilize their HIEs and avoid duplication of effort and building of disparate data silos.

PC-11(d): What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange (for example, vendor health information networks, TEFCA, private exchange networks, etc.)?

HIEs serve an important and ongoing role in ensuring that geographically relevant information is collected, standardized, and available to organizations that need it. They expand access to information by working directly with the organizations that – due to costs or technological constraints – would not otherwise participate in the exchange of clinical data. They take that data and normalize it and can directly address with data senders the policy and other barriers to the timely and accurate sharing of information.

HIEs can also eliminate or at least reduce the number of interfaces that provider and payer organizations are required to establish and maintain. By encouraging state and federal agencies to use their HIEs as the reporting source or mechanism, regulatory authorities can reduce costs and speed up the time-to-compliance for new initiatives. If the data is already at the HIE, changes in reporting requirements only require one HIE to build the interfaces needed to facilitate reporting, rather than all providers or payers that are regulated by that particular organization.

HIEs also support and facilitate use cases that TEFCA does not support. Under a TEFCA-style framework, clinicians have to actively search from within their EMR for data that may or may not exist, taking up valuable clinical time. Many HIEs provide a “push” service to deliver patient data directly into the clinician’s EMR so that it is available at the point of care without unnecessary clicks and time wasted.

PR-7: What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for, or combined with, efforts needed to support interoperability?

CMS could streamline the reporting process and reduce the administrative burden of making data available by implementing measures that encourage reporting and other information sharing processes to be made through HIEs. Doing so would reduce the number of interfaces



that providers need to develop. It would also permit data to be normalized in one location instead of across multiple systems. Finally, it would leverage the significant federal funds that have already been invested in HIEs to develop infrastructure and expertise in this area, allowing the benefits of that investment to be realized rather than requiring providers to build something new.

CMS could also consider encouraging HIE and TECCA participation by providers and payers through incentives or disincentives, with specific requirements around what constitutes a meaningful sharing of data by having the state or regional HIE validate and attest to the successful sharing of the data in question. This would ensure that providers not only share data, but that the data they are sharing is accurate and actionable. If providers are going to be required to invest in data sharing services, HIEs can help make sure that those costs have the most downstream benefit possible.

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Thank you for the opportunity to provide commentary.

Respectfully submitted,

A handwritten signature in black ink, reading "Janice L. Lee". The signature is written in a cursive, flowing style.

Dr. Jan Lee
Chief Executive Officer





2025-06-16 DHIN Response to Health Technology Ecosystem RFI

Final Audit Report

2025-06-16

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