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# Joint Legislative Oversight and Sunset Committee



**Delaware Health Information Network**

**2019 Draft Report**

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**A NOTE ABOUT THIS DRAFT REPORT**

The information provided in this report is taken from the Joint Legislative Oversight and Sunset Committee (“Committee”) Performance Review Questionnaire, as it was completed by the agency under review. When appropriate, the Analyst who prepared this report made minor changes to grammar and the organization of information provided in the questionnaire, but no changes were made to the substance of what the agency reported. Any points of consideration that arose while analyzing the questionnaire and compiling this report are addressed in the section titled “Additional Comment from the Committee Analyst.” It is the intent of the Analyst to make any substantive changes that may be required, as the result of findings made through the review processes, in the final version of this report.

The statutes governing and applying to the agency under review are included as Appendices to this Draft Report. They are included only as a reference for Joint Legislative Oversight and Sunset Committee members, and may not be included in the Final Report.

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## **AGENCY HISTORY**

The Delaware Health Information Network (“DHIN”) established in 1997 by statute, under the direction of the Delaware Health Care Commission. The State committed to partner in funding DHIN over a five-year period, with the stated expectation that DHIN would be financially self-sustaining by the end of that time.

DHIN “went live” in 2007 and became the first operational statewide health information exchange in the nation.<sup>1</sup> After an amendment to the enabling statute in 2010, DHIN became a semi-autonomous, not-for-profit public instrumentality of the State of Delaware.<sup>2</sup> The State of Delaware is now a customer of DHIN’s services, paying on the same footing as other customers for the same or similar services. Fiscal year 2012 was the last year DHIN received any funds through the Capital Bond Bill.

DHIN is currently operating as a statutory not-for-profit instrumentality of the State of Delaware with the rights, obligations, and privileges with the purpose to promote the design, implementation, operation, and maintenance of facilities for public and private use of health care information in the State.<sup>3</sup> DHIN’s statutory mission is to develop and operate a statewide health information network integrating patient satisfaction, clinical, and financial data sources to inform decisions. The law intends for DHIN to be a public-private partnership for the benefit of all citizens of Delaware.

## **JUSTIFICATION AND NEED FOR EXISTENCE**

At the time of DHIN’s creation, electronic exchange of health information was in its nascent stage. There was no central delivery method for clinical results to improve healthcare delivery in Delaware. The sound analysis and access of health data is a critical component to any state-based healthcare reform effort.

DHIN was formed to advance the creation of a statewide health information and electronic data interchange network for public and private use, to be a public-private partnership for the benefit of all citizens of Delaware, and to address Delaware’s needs for timely, reliable, and relevant health care information.

Over the past decade, DHIN has proven its value in helping Delaware in its efforts to achieve the “Triple Aim of Healthcare” which is defined as improved quality of care, improved patient experience, and lower costs. More than 14 million clinical results and reports post to DHIN each year and the system includes 2.5 million patient records from all 50 states. DHIN currently serves all of Delaware’s acute care hospitals, long-term care, and skilled nursing facilities. DHIN also serves nearly all of Delaware’s medical providers who make orders.

Over the past several years, DHIN operations have assisted with the State’s focus on the Roadmap to Health.<sup>4</sup> The Health Care Claims Database is a unique and key component of this effort, housing both

<sup>1</sup> Analyst Note: This information taken from <https://dhin.org/about> on March 12, 2019.

<sup>2</sup> Analyst Note: As defined by the Internal Revenue Service (“IRS”) an “instrumentality” is an organization created by or pursuant to state statute and operated for public purposes. Generally, an instrumentality performs governmental functions, but does not have the full powers of a government, such as police authority, taxation, and eminent domain.

<sup>3</sup> See 16 *Del. C.* § 10301.

<sup>4</sup> Analyst Note: DHIN is possibly referring to the DHSS established initiative “Delaware’s Road to Value,” which came from House Joint Resolution 7, approved on September 9, 2017. This legislation authorized the Secretary of DHSS to undertake actions necessary to establish a health care benchmark. The Delaware Health Care Claims Database was created in anticipation of this initiative.

clinical and claims data, coupled with analytic tools to support insights into healthcare spending in Delaware.<sup>5</sup>

In addition to serving Delaware’s medical facilities and providers, DHIN is poised to serve in the event of an emergency or disaster situation. DHIN is aware that its services would be vital to the delivery of healthcare if the State of Delaware faced an emergency event or disaster. The safety and security of its information is one of DHIN’s greatest strengths. The timeliness of data delivery and the ability to recover from a disaster or emergency are critical to DHIN’s ability to serve as Delaware’s health information exchange. In order to be prepared to serve in this capacity, DHIN has developed and routinely tested its business continuity and disaster recovery plans.

An independent review completed by Maestro Strategies monetized DHIN’s value, by calculating the following:<sup>6</sup>

- DHIN has saved data senders nearly \$7 million by delivering results to enrolled providers in 2013 alone.
- DHIN has saved enrolled practices a collective \$885,000 in electronic health record interface implementation
- DHIN saved insurance companies and consumers \$10 million annually in the reduction of duplicate radiology and lab tests.<sup>7</sup>

In summary, DHIN saves time, money, and lives by providing medical professionals with secure and immediate access to up-to-date test results, reducing duplicated testing, leveraging technology and reducing paper records, and improving the speed and quality of care. As DHIN enters its next decade, it continues to modernize and provide value beyond result delivery, delivering success as a public-private partnership, and helping position Delaware as a national leader in health information exchange. Without DHIN, Delaware would lose its data exchange broker and a centralized source for Delaware’s clinical data.

### **JOINT LEGISLATIVE OVERSIGHT AND SUNSET COMMITTEE REVIEW HISTORY**

The Joint Legislative Oversight and Sunset Committee (“JLOSC”) reviewed the DHIN in 2010. At the time of review, the committee was known as the Joint Sunset Committee (“JSC”). The Committee made specific recommendations as follows:

Recommendation #1: Amend the statute to provide state fiscal oversight of the DHIN.

Recommendation #2: Management should immediately implement control procedures to ensure that all DHIN financial information reported to stakeholders is reconciled to both Delaware Financial Management System (“DFMS”) and the project management system.

<sup>5</sup> Analyst Note: On July 21, 2016, Senate Bill 238 created the Delaware Health Care Claims Database to be administered and operated under the existing DHIN framework.

<sup>6</sup> Maestro Strategies is identified in JLOSC questionnaire responses as a company that evaluates health information exchanges.

<sup>7</sup> Response to JLOSC Questionnaire, pg. 33, indicates that these savings estimates were based on data from 2009-2013 that saw a 64% reduction in high volume and high cost lab tests and a 20% reduction in high cost, high volume radiology tests.

Recommendation #3: Management should provide complete and timely reporting of the DHIN financials. Reporting should include budget to actual reports of revenue and expenditures and include progress reports that detail projected timelines.

Recommendation #4: Comply with state law and enforce the reporting requirements of the Bond Bill.

Recommendation #5: Management should implement a sustainability plan and corresponding business plan that will ensure financial viability into the future.

Recommendation #6: Research and explore long-term care and home health care opportunities to expand DHIN across the continuum of care.

Recommendation #7: Explore the functionality that will help practices that are not ready to embrace technology and the financial investment meet the “meaningful use” criteria in ARRA (stimulus) in order to qualify for Medicare/Medicaid incentive payments and report back to the JSC regarding the DHIN’s continuing progress.

Recommendation #8: Define an appropriate and cost-effective approach to implementing electronic eligibility verification and claims submission through DHIN as required by the State Health Information Exchange Cooperative Agreement Program under ARRA and report back to the JSC

Recommendation #9: Continue to demonstrate the value of health information exchange and attempt to connect all hospitals in the state to DHIN.

Recommendation #10: The DHIN provide the JSC with reports making sure that those challenges with regard to the signatures between the Delaware Health Care Commission and the Department of Health and Social Services be addressed.

Recommendation #11: Develop a conflict of interest policy.

Recommendation #12: Develop a process for measuring how the DHIN is keeping up with the latest technology.

Recommendation #13: Develop skills sets for Board appointees.

Recommendation #14: Develop a policy for performance evaluation and bonus structure evaluation for employees.

Recommendation #15: Develop a policy for performance evaluation and bonus structure evaluation for contracted employees.

Recommendation #16: Report back to the JSC relating to the process for reimbursing a funding source (i.e. hospitals, labs, etc.) and discussions or advancement regarding the development of a policy for reimbursement.

In April of 2012, the JSC released DHIN from sunset review without reporting requirements. The following was the progress highlights concerning the 2010 JSC Recommendations:

- Pursuant to the FY 2012 Bond Bill, DHIN was required to submit a business plan to the members of the Bond Bill Committee, among others. The business plan was submitted on September 16, 2011; subsequent correspondence dated September 28, 2011 from the co-chairs of the Bond Bill Committee informed DHIN that they endorse and approve the business plan.
- Successful execution of DHIN’s FY 2012 budget will establish a solid fiscal foundation for FY 2013, permitting DHIN to operate independently of any Bond Bill funding.
- Preliminary results from an actual usage study show that Delaware has achieved measurable and significant savings from DHIN, including a greater than 30% reduction in a sub-set of high cost laboratory tests.
- 100% of Delaware acute care hospitals participate in DHIN.
- More than one million unique patients represented in the master patient index, representing 90% of Delaware residents, as well as patients from other states.
- 88% of providers currently practicing in Delaware are enrolled in DHIN. DHIN expects this percentage to reach 95% by June 30.
- More than 5,000 providers and staff at 551 Delaware practices are live on DHIN; 226 of these practices receive clinical results/reports exclusively through the DHIN. (As of 3/29/2012)
- 80% of laboratory tests ordered or performed in Delaware are reported through DHIN (as of September 2011). DHIN is working with the Department of Health & Social Services to ensure that all required reporting of clinical data to any state agency can be accomplished through DHIN.
- DHIN offers providers and hospitals the tools necessary to attest for Meaningful Use by enabling exchanges of health information outside of their respective organizations.

### **MISSION, GOALS, OBJECTIVES, & AUTHORITY**

DHIN’s mission is to serve providers and care consumers through innovative solutions that make health data useful. DHIN’s mission, as outlined in statute:<sup>8</sup>

- Promote more efficient and effective communication among multiple health care providers, including, but not limited to, hospitals, physicians, payers, employers, pharmacies, laboratories and other health care entities.
- Create efficiencies in health-care costs by eliminating redundancy in data capture and storage and reducing administrative, billing and data collection costs.
- Create the ability to monitor community health statuses.

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<sup>8</sup> See 16 *Del. C.* § 10303.

- Provide reliable information to health-care consumers and purchasers regarding the quality and cost-effectiveness of health care, health plans, and health-care providers.

The vision of DHIN is to develop a network to exchange real-time clinical information among all health care providers (office practices, community clinics, hospitals, laboratories, diagnostic facilities, etc.) across the state to improve patient outcomes and patient-provider relationships, while reducing service duplication and the rate of increase in health care spending.

The basis for interoperability among health care providers in the State of Delaware is served by DHIN's five primary goals:

- To improve the care received by patients of Delaware's health care system and to reduce medical errors associated with often inaccurate and incomplete information available to providers of medical care.
- To reduce the time required and financial burdens of exchanging health information among health care providers and payers (necessary for patient care), by addressing the currently isolated and un-integrated model of distribution methods and dramatically increasing use of electronic means.
- To improve communication between healthcare providers and their patients to provide the right care at the right time based on the best available information.
- To reduce the number of duplicative tests to afford specialists a more comprehensive view of the patient upon referral from a primary physician. To expedite the reporting of consultant opinions and tests or treatments between specialists and the referring physicians.
- To improve the efficiency and value of electronic health records (EHR) in the physician's office. To assist those physicians without an EHR to better organize and retrieve test results.

In addition, DHIN sets annual corporate goals, which follow best practices for a balanced scorecard approach. For fiscal year 2019, DHIN's Board of Directors approved the following corporate goals:

- Goal 1 – Financial
  - Introduce a pricing structure that incentivizes sending DHIN data
    - Contributes to a sustainable business model based on value
    - Allows for possible lowering of our data sender and payer participation fees or enhanced services for same fees
- Goal 2 – Customer
  - Complete all phases of DHIN's technology refresh (Community Health Record, MIRTH Results, Medication History, Image Viewing, Clinical Gateway)<sup>9</sup>
    - Produce additional value for current DHIN participants

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<sup>9</sup> MIRTH Results definition not supplied by DHIN, could be related to Mirth Connect, also known as Nextgen Connect, which is a cross-platform interface engine used in the healthcare industry that enables the management of information using bi-directional sending of many types of messages.

- Improve stakeholder confidence
    - Contribute to a sustainable business model based on value
  - Enhance at least one current service or introduce a new service to attract new customer segments.
    - Develop new customer segments
    - Sustainable business model based on value
    - Diversify revenue stream
- Goal 3 – Internal Processes
  - Implement the Health Care Claims Database
    - Open new market segments
    - Diversification of revenue stream
    - Contribute (over time) to a sustainable business model based on value
    - Contribute to a viable analytics service
- Goal 4 – Learning and Growth
  - At least 30% of DHIN employees receive certification at the intermediate level for at least one additional Information Technology Infrastructure Library (“ITIL”) course and produce process maps, responsibility assignment matrix (“RACI”) charts, critical success factor charts (“CSFs”), and key performance indicators for at least 70% of defined ITIL processes.
    - Part of implementing Gartner’s suggested 5-year roadmap<sup>10</sup>
    - Improved portfolio management
    - More clearly defined internal processes

All levels of the DHIN team are engaged in goal setting, and DHIN follows the Balanced Scorecard model in setting, monitoring, and attaining corporate and personal goals.

Each year, the Board of Directors defines DHIN’s strategic organizational goals. From this set of organizational goals, employees establish personal goals, approved by the Chief Executive Officer, that demonstrably contribute to DHIN achieving its Board-defined goals.

At the mid-point of the fiscal year, each employee meets with his or her immediate supervisor to review performance to date against goal and again at the close of the fiscal year.

In addition to personal goals, DHIN team members also serve as business owners and service owners for DHIN’s service offerings. The teams conduct quarterly internal service meetings with DHIN’s CEO, reporting on the adoption, utilization, performance, and return on investment for each of the twenty service offerings.

DHIN’s management team provides monthly reports on key metrics, which contribute to the monthly Board report presented by DHIN’s CEO. The members of the Board and executive team meet quarterly, per the by-laws, to review DHIN’s financial reports.

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<sup>10</sup> In 2016, DHIN consulted with industry leader Gartner to develop a five-year roadmap for maturing as an organization.

As part of the State’s focus on the healthcare roadmap, members of the DHIN team work very closely with the Department of Health & Social Services (“DHSS”) and Delaware Health Care Commission on shared goals, including the Delaware Health Care Claims Database and State Innovation Model funded projects. DHIN’s CEO serves on the Health Care Commission; Delaware Center for Health Innovation Board of Directors, Quality & Safety Committees of Highmark Blue Cross Blue Shield of Delaware and Christiana Care Health System, and meets regularly with DHSS leadership.

Additionally, DHIN works collaboratively with the Lt. Governor’s Office on health-related projects, including representation at the Behavioral Health Consortium and associated sub-committees.

DHIN’s own Board of Directors, per statute, includes representatives from the Office of Management and Budget, Department of Technology and Information, Department of Health & Social Services and Office of the Controller General, all of whom are appointed by the Governor. The DHIN Board receives monthly reports from the DHIN executive team on progress against corporate goals, financial status, and organizational challenges/opportunities.

Representatives from all agencies and the public are invited to DHIN’s monthly Town Hall meetings, which are held both in-person and by phone.

At a more granular level, DHIN team members work directly with representatives from nearly all State agencies on a variety of data-related projects. These agencies include:

- Department of Health & Social Services
- Division of Public Health
- Delaware Health Care Commission
- Division of Medicaid & Medical Assistance
- Department of Correction
- Division of Substance Abuse & Mental Health
- Delaware Office of Management and Budget
- State Employee Benefits Committee
- Department of Technology & Information

### **COMPOSITION OF THE BOARD OF DIRECTORS**

The governing statute requires DHIN to be managed and operated by a Board of Directors consisting of 19 members. It is the intent that the membership of the Board includes individuals with various business, technology, and healthcare industry skills committed to managing the Corporation in an efficient, effective, and competitive manner. The Board shall be comprised of the following members:<sup>11</sup>

- The Director of the Office of Management and Budget or the Director's designee;
- The Chief Information Officer of the Department of Technology and Information or the Chief Information Officer's designee;
- The Secretary of the Department of Health and Social Services or the Secretary's designee;
- The Controller General or the Controller General's designee;
- Six members, appointed by the Governor, including at least one person who shall represent the interests of medical consumers and at least three with experience and/or expertise in the health-care industry;

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<sup>11</sup> 16 *Del. C.* § 10302

- Three members appointed by the Governor representing hospitals or health systems;
- Three members appointed by the Governor representing physicians;
- One member appointed by the Governor representing businesses or employers; and
- Two members appointed by the Governor representing health insurers or health plans

Each member can serve two consecutive, three-year terms, with initial term appointments staggered by the Governor; each member continues to serve beyond their term end until a successor is appointed. Members must attend all scheduled meetings either in person or by electronic means. A member may be removed from the Board with the approval of the Governor upon recommendation by the Board if a member is absent for three consecutive meetings without adequate reason or fails to attend at least half of regularly scheduled meetings during any calendar year.

A member may resign by providing a written resignation notice to the chair and secretary of the Board. Any submitted written resignation becomes effective according to the date included in the notice. The chair or the Board determines the resignation effective date in events where a resignation notice does not include a date. Members who have resigned from a term will not be eligible for re-appointment to the Board for a period of one year. DHIN has never had a board member removed for any reason other than resignation or expiration of a term.

The Board has the ability to conduct business by reaching a quorum, a simple majority of currently appointed members. The Board will elect a chairperson, vice-chairperson, and secretary. The Board will establish an Executive Committee comprised of seven members, to include the chairperson, vice-chairperson, secretary and four other members elected by a majority of the Board. The Executive Committee acts on behalf of the full Board in instances that prevent the full Board from reasonably convening in order to conduct business in a timely manner.

The Board currently has 16 appointed members.<sup>12</sup> There are currently three vacancies, which include a consumer representative and a representative from the Office of the Controller General.<sup>13</sup> DHIN forwards information concerning board vacancies to the Governor's office.

### **Board Compensation**

Board members do not receive any compensation but may authorize, by resolution, reimbursement of reasonable expenses incurred in the performance of their duties. Such authorization may prescribe the procedure for approval and payment of such expenses by designated officers of DHIN. Board members can serve DHIN in other capacities, and may receive compensation for such services. Any such compensation is subject to all applicable requirements concerning conflict of interest and disclosure.

### **Board Member Trainings**

A responsibility of DHIN's Chief Executive Officer includes developing a comprehensive training and orientation curriculum for new members. Currently, newly appointed Board members meet with DHIN leadership prior to attending the first board meeting and are provided background information on DHIN, a system demonstration, current status of DHIN, plans for the future, and an overview of Board member duties.

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<sup>12</sup> Board roster available in Appendix C

<sup>13</sup> Analyst Note: Information on the third vacancy not provided.

DHIN introduced training in 2019 to allow members to attend a voluntary offsite training session with an outside facilitator. This training will better equip members to advocate for DHIN within their organizations and beyond.

### **Avoiding Conflicts of Interest**

As a public instrumentality of the State of Delaware, Board members and employees of DHIN are subject to the laws regulating the conduct of officers and employees of the State, as set forth in 29 *Del. C.* § 5806. All board members shall be required, upon their appointment and on an annual basis thereafter, to sign a conflict of interest statement on a form approved by the Executive Committee.<sup>14</sup>

### **STAFFING**

DHIN currently employs 30 staff members.<sup>15</sup> With DHIN’s expanded role via statutory obligations, adequate staff is a necessity. Otherwise, work is not completed and responsiveness is jeopardized. The DHIN Board of Directors considers staffing requests annually and generally approves additional resources as requested. Internally, the DHIN management team employs enterprise education and awareness to work collaboratively to meet deadlines.

DHIN posts vacancies on their website, as well as job boards and social media websites. The hiring manager reviews received applications and multiple rounds of interviews occur with potential candidates. Generally, both staff and management team members submit feedback regarding potential candidates. After the hiring decision process is completed, a new team member is hired and an onboarding session occurs on the first day of employment. Each new hire receives an employee manual. Training and education is a central part of DHIN’s staff philosophy. At least one of DHIN’s annual corporate goals will involve ongoing staff training initiatives. Additionally, each staff member is required to incorporate training into his or her yearly personal goals. DHIN launched its Information Technology Infrastructure Library (“ITIL”) two years ago to establish a strong commitment to staff training. ITIL is a set of detailed practices for service management in the information technology (“IT”) field that focuses on aligning IT services with business needs. All DHIN staff members are required to hold at least an intermediate level certification with ITIL training. The goal is to have the majority of DHIN’s management team certified at the expert level by 2020.

DHIN staff work with state agencies to coordinate services. DHIN maintains Memoranda of Understanding (“MOUs”) with the following State agencies or departments:<sup>16</sup>

- **Division of Public Health** – Governs data sharing/reporting for the following services provided:
  - Syndromic Surveillance.
  - Electronic Laboratory Reporting.
  - Immunization Update/Query.
  - Newborn Screening.
  - DPH Laboratory Information System

<sup>14</sup> Executive committee defined on page 7 of the DHIN by-laws provided in Appendix E.

<sup>15</sup> Detailed listing of staff members and their responsibilities available in Appendix D and DHIN organizational chart available in Appendix E

<sup>16</sup> Analyst Note: DHIN provided MOUs referenced and are available upon request.

- **Delaware Health Care Commission** – Outlines agreement for services (previously used for provider scorecard; now, payer webinars and health care claims database) performed by DHIN in exchange for State Innovation Model funding.<sup>17</sup>
- **Division of Medicaid & Medical Assistance** – Outlined pilot agreement for consumer mobile alert system.

As part of the Health Care Claims Database work, an MOU between DHIN and the collaborating State agencies (Delaware Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, Division of Medicaid and Medical Assistance, and Delaware Health Care Commission) is in progress.<sup>18</sup>

### **COMPLAINT AND DISCIPLINARY PROCESS**

Outlined in DHIN’s rules and regulations is the complaint process.<sup>19</sup> A Dispute Resolution Committee resolves disputes regarding DHIN policies, procedures, and regulations. Members of the DHIN Board, appointed by the Board chair, compose the Dispute Resolution Committee. That committee may create rules and regulations for administering any such dispute; relief provided to an aggrieved party includes financial penalties, suspension, or termination of an entity or individual’s use or participation of DHIN. In the event that a party is dissatisfied with the decision of the Dispute Resolution Committee, the decision is appealable to the Delaware Superior Court. DHIN is not presently aware of any instances when any party has triggered this dispute resolution procedure.

DHIN has received few complaints. Received complaints originated with data senders, insurers, or healthcare providers that have periodically questioned fees charged for DHIN’s services or voiced concerns about service interruptions. Complaints received from consumers, have periodically involved requests to remove an individual from the Community Health Record. This is resolved as outlined in the rules, regulations, and DHIN health record forms available on the DHIN website. There have been no complaints filed with the Attorney General’s office and no complaint investigations conducted involving DHIN.

DHIN also has a disciplinary process in place for employee conduct. It is DHIN’s policy that any conduct, which, in its view, interferes with, or adversely affects employment could be grounds for disciplinary action, up to and including termination. Disciplinary action could include any or all of the following: verbal counseling/warnings, written warnings, and termination. Factors considered in ascertaining the appropriate disciplinary actions include:

- Seriousness of conduct.
- Employment record.
- Employee’s ability to correct conduct.
- Action taken with respect to similar conduct by other similarly situated employees.
- Surrounding circumstances.

If a situation requires an investigation, DHIN’s expectation is that employees cooperate fully with the investigation. DHIN’s employee disciplinary policy does not alter the at-will nature of the employment

<sup>17</sup> Analyst Note: State Innovation Model funding ended on January 31, 2019.

<sup>18</sup> Analyst Note: It is unknown if this MOU was completed, no additional information was provided.

<sup>19</sup> Analyst Note: Complete DHIN Rules and Regulations provided in Appendix B.

relationship. DHIN or the employee may terminate the employment relationship at any time with or without reason, with or without prior notice.

## **ENACTED LEGISLATION IMPACTING THE COMMISSION**

### **State Legislation – Substantive Amendments to DHIN**

139<sup>th</sup> General Assembly, July 1997, HB 276 – Created a public instrumentality of this State known as the DHIN under the direction and control of the Delaware Health Care Commission ('Commission') to promote the design, implementation, operation and maintenance of facilities for public and private use of health care information in the State.

143<sup>rd</sup> General Assembly, July 2006, SB 339 – Amended the composition of DHIN. This bill deletes the Delaware Health Care Coalition from the Delaware Health Information Network Board of Directors, since that organization no longer exists, and replaces it with the Secretary of the Department of Technology and Information, which did not exist when the legislation was originally enacted.

145<sup>th</sup> General Assembly, July 2010, SB 231 – Removed DHIN from the organizational structure of the Delaware Healthcare Commission. This bill resulted from input from DHIN and the Joint Sunset Committee. The bill implemented greater accountability and transparency by requiring annual reports including annual certified audits to be submitted to the Governor and the General Assembly. The bill also modified the makeup of the Board by adding representation from the healthcare industry and government, including the State's Director of Management and Budget and the Controller General.

148<sup>th</sup> General Assembly, May 2015, HB 64 – Authorizes the use of Medical Orders for Scope of Treatment (“DMOST”) in Delaware and for DHIN to create an electronic registry to maintain and store DMOST forms. DMOST forms allow Delawareans to plan ahead for health-care decisions, express their wishes in writing, and both enable and obligate health care professionals to act in accordance with a patient's expressed preferences.<sup>20</sup>

148<sup>th</sup> General Assembly, July 2016, SB 238 – Created the Delaware Health Care Claims Database to be administered and operated under the existing DHIN framework. The Delaware Health Care Claims Database was created in order to assist with Delaware's ongoing work to transform the State's health care system from a fee-for-service system to a value-based system that rewards health care providers for quality and efficiency of care. This bill created the basic structure and parameters of the Health Care Claims Database, which was subject to further guidance to be set forth in rules and regulations to be promulgated by the DHIN, in continued consultation with the Department of Health and Social Services, the Health Care Commission, and stakeholders in the health care community.

149<sup>th</sup> General Assembly, September 2017, HJR 7 – Authorized the Secretary of DHSS to undertake actions necessary to establish a health care benchmark. In anticipation of this initiative, legislation passed the year prior created the Delaware Health Care Claims Database. In response to House Joint Resolution 7, DHSS established the “Delaware's Road to Value” initiative.<sup>21</sup>

149<sup>th</sup> General Assembly, June 2018, SB 236 – Created a one-time appropriation of two million dollars in General Funds to the Office of Management and Budget (“OMB”) for the development of the Delaware Health Care Claims Database. The bill also stated that the Delaware Health Information Network might

<sup>20</sup> Analyst Note: Analyst added this legislation to the supplied listing from the JLOSC questionnaire responses.

<sup>21</sup> Analyst Note: Analyst added this legislation to the supplied listing from the JLOSC questionnaire responses.

seek technical assistance from DHSS, in collaboration with the Delaware Health Care Commission, in support of DHIN’s efforts to develop long-term sustainable funding strategies for the Health Care Claims Database.

149<sup>th</sup> General Assembly, August 2018, SB 227 – Created a Primary Care Reform Collaborative under the Delaware Health Care Commission, which required all health insurance providers to participate in the Delaware Health Care Claims Database. This bill also required individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate for the next three years.

149<sup>th</sup> General Assembly, August 2018, SB 230 – Set annual reporting requirements for insurance carriers with regard to coverage for serious mental illness and drug and alcohol dependencies. The bill also added a new set of annual reporting requirements for insurance carriers providing mental illness and drug and alcohol dependencies benefits, and the carriers' compliance with the Mental Health Parity and Addiction Equity Act of 2008. Additionally, the bill set annual reporting requirements for insurance carriers regarding coverage for serious mental illness and drug and alcohol dependencies for recipients of public assistance.

#### **Current State Legislation – Directly Impacts DHIN Operations or Functions**

DHIN is not aware of any currently proposed or pending legislation that would directly affect DHIN operations or functions. There were three bills passed during the last legislative session that have direct impact on DHIN operations or functions.

#### **Federal Legislation – Directly Impacts DHIN Operations or Functions**

On February 17, 2009, the Health Information Technology for Economic and Clinical Health (“HITECH”) Act was signed into law. HITECH created funding opportunities for health information technology. One such opportunity is that of health information exchange, for which the DHIN is exceptionally well positioned to take advantage when funding opportunities are made available through the U.S. Department of Health and Human Services, specifically the Office of the National Coordinator (“ONC”). As the state-sanctioned health information exchange, only DHIN can receive federal grants pertaining to health information exchanges (“HIEs”) in Delaware. In 2015, DHIN received two, two-year grants totaling \$3.1 million from ONC. Requirements as a grant recipient included adherence to federal procurement rules and document retention policies.

HITECH also added additional privacy and security rules, which were included in the updated Health Insurance Portability and Accountability Act (“HIPAA”), which was part of the American Recovery and Reinvestment Act of 2009. While HIEs are not defined as covered entities by HIPAA, HIEs are nonetheless contractually obligated as business associates of the data senders to meet the requirements of the HIPAA privacy and security rules. DHIN has ensured its own HIPAA compliance since its inception, even though it was not required to do so prior to 2009.

On December 13, 2016, the 21st Century Cures Act, also known as the Trusted Exchange Framework and Common Agreement (“TEFCA”) was signed into law. TEFCA is a vast healthcare bill that funds medical research through improved technology and science and includes provisions for Application Programming Interfaces (API) use to promote interoperability.

- The law states that the Office of the National Coordinator (ONC) within the Department of Health and Human Services has the authority to certify health IT software, which must allow health information to be accessed and exchanged without special effort.
  - Fines up to one-million dollars per occurrence may be imposed for refusing to share information that it is legal to share, deliberately making it hard to share information, or sharing deliberately incomplete data sets. These requirements may result in DHIN receiving more data than in the past.
  - Provisions of the law require improved patient access to their data. Since DHIN aggregates data from many sources, DHIN is the obvious best place for patients to get access to all of their health data with the least effort on their part. DHIN has made available a Personal Health Record, which can be utilized by patients for this purpose. DHIN is actively working with hospitals and practices to encourage adoption of this tool.
- In promoting interoperability, the law directs ONC to set up TEFCA to share health data among healthcare systems, insurers and others.
- TEFCA will implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information, and adopt best practices including those related to privacy and security.

The Substance Abuse and Mental Health Services Administration (“SAMHSA”) amended Part II of the Substance Abuse Confidentiality Regulations (“Part II”) in 2017 and again in 2018. This is the federal confidentiality law and regulations that protect the privacy of substance use disorder (“SUD”) patient records by prohibiting unauthorized disclosures of patient records except in limited circumstances. Originally enacted in the 1970s, the intent of SUD legislation is to encourage individuals with SUDs to enter and remain in treatment. Part II creates further limitations on use and sharing of behavioral health and substance abuse data. While there is movement at the federal level to make this less restrictive in the hopes of assisting with tackling the opioid epidemic, state statutes still restrict the sharing of this data. At this point, federal law does not permit sharing personally identifiable data related to these conditions.

### **Recent Judicial Decisions Affecting DHIN**

To DHIN’s knowledge, *Gobeille v. Liberty Mutual Insurance Company* (decided March 1, 2016) is pertinent, as it limits the scope of data available to a state’s all-payer claims database. *Gobeille v. Liberty Mutual Insurance Company* held that the Employee Retirement Income Security Act (“ERISA”) preempted a Vermont state law requiring the disclosure of certain information relating to health care services to the extent that the state law applied to ERISA plans.

### **PENDING LEGISLATION**

There is no known pending legislation that would directly affect the functions or operations of DHIN.

### **ADMINISTRATIVE PROCEDURES ACT COMPLIANCE**

DHIN is authorized under 16 *Del. C.* § 10306 to promulgate its own rules and regulations.<sup>22</sup> Additionally, the Delaware Health Care Commission had enacted rules and regulations regarding DHIN. Prior to July of 2017, the State supplied a Deputy Attorney General (“DAG”) for legal counsel, who had periodically reviewed the DHIN’s rules and regulations. On July 18, 2017, DHIN received notice that the Delaware Attorney General’s Office would no longer provide legal counsel to DHIN. As a result and at its own expense, DHIN hired private counsel Scott W. Perkins, Esq. of the Saul Ewing Arnstein & Lehr law firm to represent DHIN. DHIN’s private counsel primarily assists in vendor contract reviews, matters of

<sup>22</sup> Current Rules and Regulations are in Appendix B

privacy and security concerns, and the Health Care Claims Database, but is also available as needed to address DHIN’s broader legal issues.

DHIN is reviewing its governing statute as well as its rules and regulations in order to apply general updates to reflect DHIN’s current operational practices and to address any deficiencies discovered during the review process.<sup>23</sup> DHIN has already identified a couple of areas in which it intends to draft rule and regulation changes. DHIN is considering a revision to its rules and regulations to remove reference to the Health Care Commission in order to separate itself from the Health Care Commission. DHIN is also planning an update to its participation requirements in order to mandate participation by all insurers. DHIN is consulting with its legal counsel regarding proposed changes.

### **FREEDOM OF INFORMATION ACT (“FOIA”) COMPLIANCE**

To date, there have been no FOIA requests received by DHIN and there have been no complaints that DHIN is aware of concerning FOIA violations.

DHIN is prepared to respond to FOIA requests promptly and in agreement with the State of Delaware’s FOIA response protocol. DHIN is unable to disclose patient data in connection to any FOIA request and advises that some FOIA requests could take up to ten business days to complete. DHIN’s FOIA policy includes consulting with their contracted legal counsel regarding situations where the content of a requested document is fully or partially exempt from public record. Any FOIA requests greater than twenty pages in length will be subject to a fee of ten cents per page starting with the twenty-first page of the request.

Prior to July of 2017 DHIN’s DAG had reviewed the provisions of the Public Integrity Act with DHIN. DHIN held a Board of Directors meeting in October of 2018 and their private counsel reviewed the conflict of interest form and other components of the Public Integrity Act with DHIN.

DHIN posts public meeting announcements on both the State of Delaware public meeting calendar and DHIN’s website at least seven days prior to the scheduled meeting. DHIN posts transcribed meeting minutes on its website after receiving approval at the next scheduled meeting. Within the past three calendar years, DHIN has conducted the following executive sessions:

July 25, 2018: Executive Session: [Pursuant to DE Code – Title 29, Chapter 100, §10004 (b)(9)]

ACTION ITEM: End of Fiscal Year Personnel Matters

June 22, 2018: Executive Session: [Pursuant to DE Code – Title 29, Chapter 100, §10004 (b)(9)]

ACTION ITEM: End of Fiscal Year Personnel Matters

July 19, 2017: Executive Session: [Pursuant to DE Code – Title 29, Chapter 100, §10004 (b)(9)]

ACTION ITEM: End of Fiscal Year Personnel Matters

July 20, 2016: Executive Session: [Pursuant to DE Code – Title 29, Chapter 100, §10004 (b)(9)]

ACTION ITEM: End of Fiscal Year Personnel Matters

The meeting minutes only record the outcomes of held Executive Sessions.

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<sup>23</sup> Analyst Note: DHIN updated Rules and Regulations pertaining to the Delaware Health Care Claims Database on 10/01/2017, 21 DE Reg. 293, 03/01/2018, 21 DE Reg. 712, and on 12/01/2018, 22 DE Reg. 465. It is unknown if legal counsel was consulted during these changes as they were not mentioned in submitted JLOSC questionnaire responses and attorney information was not provided in the Register of Regulation volumes that contain the changes.

**Process for Public Access to Health Information:**

DHIN has published a process on their website in which citizens can acquire their health records and audit the access to their network information by submitting a request form to DHIN. The form is available on DHIN’s website. In order to protect the safety and security of personal health information, only in person or mail requests are accepted. All requests must include a raised notary seal in order to validate the identity of the person making the request. For the convenience of the requester, DHIN offers notary services for those making their request in-person at the DHIN office. All individuals must present corresponding copies of identification, one type of must be a copy of state, or government issued identification. Once DHIN receives a request, DHIN will review the materials submitted and furnish a response to the request. An individual can contact DHIN by email or phone if there is a question concerning the accuracy or validity of their results or for any questions pertaining to who has accessed their account.

DHIN publishes the following information or educational resources for the public relating to DHIN’s activities:

- Town Hall Meetings: Monthly
- Leadership Summits: Every 18 Months
- Newsletters: Monthly or Semi-Monthly

DHIN does not have any industry or trade publications that are relevant to DHIN’s work. The following are interest groups and other entities that interact with DHIN.

<b>Interest Groups</b> (Groups affected by DHIN actions or represent others served by or affected by DHIN actions)		
<b>Group or Association</b>	<b>Address</b>	<b>E-mail Internet Address</b>
SHIEC – Strategic Health Information Exchange Collaborative	744 Horizon Ct Ste 210 Grand Junction, CO 81506-3939	e-mail: <a href="mailto:info@strategichie.com">info@strategichie.com</a> website: <a href="https://strategichie.com/">https://strategichie.com/</a>
NAHDO – National Association of Health Data Organizations	124 South 400 East, Suite 220 Salt Lake City, Utah 84111-5312	e-mail: <a href="mailto:esullivan@nahdo.org">esullivan@nahdo.org</a> website: <a href="https://www.nahdo.org/">https://www.nahdo.org/</a>

<b>National Organizations or Other Government Entities</b> (that serve as an information clearinghouse or regularly interact with the DHIN)		
<b>Group or Association Name/Contact Person</b>	<b>Address</b>	<b>Phone Number Internet Address</b>
ONC – Office of the National Coordinator for Health Information Technology Larry Jessup, Branch Chief	330 C Street Suite 7033A Washington, DC 20201	Phone number - 202-720-2861 <a href="https://www.healthit.gov/">https://www.healthit.gov/</a>

**Health Information Exchange Process for Private Organizations:**

DHIN offers nearly twenty distinct services for practices, payers, data senders, and consumers.<sup>24</sup> Private organizations exchange health information with DHIN, which can be broken down into two service types: results delivery and the community health record.

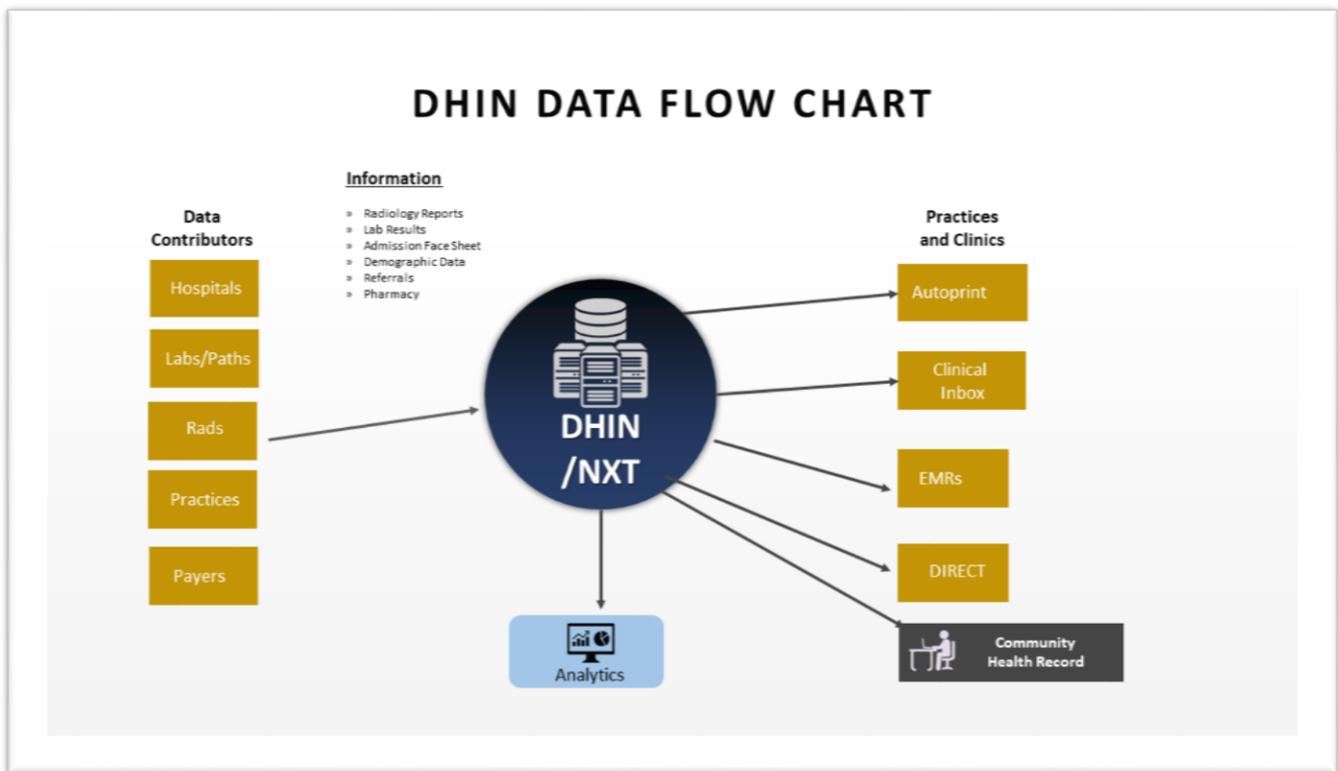
**Results Delivery**

DHIN facilitates the electronic transmission of clinical data from data sending organizations, such as hospitals, commercial laboratories and imaging centers to the ordering health care provider. Data senders include all of Delaware’s acute care hospitals, three border hospitals in Maryland, all commercial laboratories, and approximately 95% of imaging centers serving Delaware, as well as the Delaware Public Health laboratory.

DHIN supports the receipt and delivery of laboratory and pathology results, radiology reports, and a range of transcribed reports, admission, discharge, and transfer (“ADT”) files.<sup>25</sup>

Almost all health care professionals in Delaware who place clinical orders receive their results through DHIN. DHIN receives approximately 1.2 million unique results and makes approximately 1.5 million deliveries to practices each month – more than 14 million per year. These results can be shared four ways: direct, clinical inbox, auto-print, and electronic medical record (“EMR”) integration.

*The following chart illustrates that flow of information from DHIN data sender organizations to clinicians, through DHIN’s NXT platform, and the query of information through DHIN by authorized users of the system.*



<sup>24</sup> See Appendix H for complete list of services.

<sup>25</sup> Transcribed reports include hospital discharge summaries, history and physical examination reports, operative reports, and various others.

**Community Health Record**

All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. Properly privileged users can query this record for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time, and care settings is core to DHIN’s value proposition.

The Community Health Record contains health data on nearly all Delawareans, and patients from all fifty states – nearly 2.5 million in total. In addition to information from Delaware facilities on Delaware patients, DHIN also receives information on Delaware patients from providers and facilities in other states.

**Out-of-State Sources of Information:**

- DHIN and the Maryland’s HIE, Chesapeake Regional Information System for Our Patients (“CRISP”) exchange inter-state ADT notifications based on the patient’s state of residence. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets.
- DHIN exchanges data with six member hospitals of HealthShare Exchange (“HSX”), the HIE for southeastern Pennsylvania and is working on growing that number.
- DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

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**FISCAL INFORMATION**

**Revenue:**<sup>26</sup>

<b>Fiscal Year</b>	<b>Source(s)of Funds</b>	<b>Amount \$</b>
<b>FY19 (budgeted)</b>	Operating Revenue: Core Services	\$7,414,680
	Operating Revenue: Value-Added Services	\$497,628
	Non-Operating Revenue	\$45,000
	<b>Total Revenue</b>	<b>\$7,957,308</b>
<b>FY18 (actual)</b>	Operating Revenue: Core Services	\$7,082,435
	Operating Revenue: Value-Added Services	\$730,423
	Non-Operating Revenue	\$745,692
	<b>Total Revenue</b>	<b>\$8,558,550</b>
<b>FY17 (actual)</b>	Operating Revenue: Core Services	\$6,883,478
	Operating Revenue: Value-Added Services	\$615,555
	Non-Operating Revenue	\$4,469,982
	<b>Total Revenue</b>	<b>\$11,969,015</b>
<b>TOTAL \$</b>		<b>\$28,484,873</b>

**Expenditures and Net Income:**

<b>Fiscal Year</b>	<b>Total Expenditures</b>	<b>Net Income</b>
<b>FY19 (budgeted)</b>	\$9,094,262	(\$1,136,954)
<b>FY18 (actual)</b>	\$12,313,121	(\$3,754,571)
<b>FY17 (actual)</b>	\$10,469,722	\$1,499,293
<b>TOTAL \$</b>	<b>\$31,877,105</b>	<b>(\$3,392,232)</b>

<sup>26</sup> Analyst Note: DHIN provided detailed financial statements and independent auditors’ reports and are available upon request; additionally DHIN provides annual reports on its website.

**DHIN Fee Information:**

*Information is as of DHIN's FY2019 Mid-Year Financial Reforecast*

Description of Fee	Current Fee	Number of Individuals or Entities Paying Fee	Fee Revenue \$\$	Where is the Fee Revenue Deposited
Data Sender Bundle - includes 8 services listed in DHIN's service pricing guide.	See Table 1 - DHIN Data Sender Tiered Fee Schedule	25	\$4,393,958	DHIN's WSFS MMDA account.
DHIN Payer Service Bundle - includes 3 services listed in DHIN's service pricing guide.	\$0.70 Per Member Per Month	6	\$3,099,610	DHIN's WSFS MMDA account.
DHIN Ambulatory Provider Services - 8 combinations of services to choose from, as listed in DHIN's service pricing guide.	Varies based on options selected by Provider see Table 2	311	\$124,100	DHIN's WSFS MMDA account.

**Table 1 - DHIN Data Sender Tiered Fee Schedule**

based on number of unique results sent to DHIN annually

Annualized Volume	Price per result
150,000 or less	\$0.24
150,001 to 2,400,000	\$0.32
Greater than 2,400,000	\$0.35

**Table 2 - DHIN Provider Fee Schedule**

Service	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
CHR Access	X	X	X	X	X	X	X	X
ENS			X		X		X	X
CCD Exchange		X			X	X	X	X
PHR Portal				X		X	X	X
Not Signed Off								X
Price - per practice	\$400	\$200	\$500	\$500	\$300	\$300	\$400	\$800

*\*Implied \$200 discount if practice sends CCD's to DHIN*

**Fee Development Process:**

As part of its annual financial processes, DHIN creates a revenue and expense listing for each of its services, which the service business owners track. DHIN management reviews the allocations of its revenue received to ensure accuracy. In addition, DHIN management reviews each line item in its annual budget to ensure that service expense allocations are accurate and current with recent developments to DHIN's services and customer preferences.

**External Factors Affecting Revenue or Expenditures**

Since DHIN's inception, the State had provided legal counsel to DHIN. Per earlier responses, in July of 2018, the State ceased DHIN's legal counsel representation. As a result, DHIN has had to hire its own counsel, at a cost of approximately \$175,000 annually.

DHIN launched its Personal Health Record (“PHR”) service in 2017, based on an approved operating plan for the State Innovation Model (“SIM”) funds.<sup>27</sup> As such, DHIN allocated other grant funding to implement its PHR, with the knowledge that SIM funds would cover the ongoing costs.<sup>28</sup> After the service was in production, DHIN learned that those funds, \$600,000 annually, were appropriated to other activities.<sup>29</sup> Additionally, Highmark’s five-year funding commitment ended, leaving DHIN with a one million dollar annual revenue gap to fill.

DHIN currently receives SIM funds in the form of a contract with the Delaware Health Care Commission to establish the Delaware Health Care Claims Database.<sup>30</sup> The State made an additional one-time appropriation of two million dollars to provide additional support for the establishment of the Delaware Health Care Claims Database.<sup>31</sup> DHIN is working with the Delaware Health Care Commission, DHSS, and the Division of Medicaid and Medical Assistance to seek additional federal funding participation through an investment advisor public disclosure (“IAPD”) which would use the two million dollar appropriation as the State matching requirement.<sup>32</sup>

## **ACCOMPLISHMENTS**

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- First operational statewide health information exchange (“HIE”) in the nation<sup>33</sup>
- Regional footprint includes patient data from all or parts of six states and the District of Columbia
- Nearly 2.5 million patients from all fifty states included in DHIN’s master patient index
- 14 million deliveries of clinical results and reports each year
- DHIN is the first public HIE to reduce participation fees (10% in FY15; 8% in FY19)
- One of a select group of HIEs nationwide to receive the HITRUST CSF Certification, the gold standard for measuring and certifying security management programs.<sup>34</sup>
- \$7 million saved in Delaware through DHIN’s annual results delivery<sup>35</sup>
- \$10 million in annual savings from fewer duplicate tests<sup>36</sup>

<sup>27</sup> Analyst Note: Information not provided and could not be located regarding this claim. SIM funding documents indicate funds granted to DHIN were for use in supporting the Delaware Health Care Claims Database, Common Provider Scorecard, and webinar series. It is unclear how the PHR service fit into the structure of the SIM grant. DHIN’s website states that the PHR was built with a “sizable grant” from the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. See Appendix H.

<sup>28</sup> Analyst Note: It is unknown what other grant funding DHIN has received or utilized.

<sup>29</sup> Analyst Note: It is unclear if this service is still in production for an individual to create and access their PHR. There is no such service offered for patients on the DHIN website. This service is listed as one of eight bundled services in the *DHIN Data Sender Service Bundle* offered to healthcare providers per DHIN supplied document dated May 2018 in Appendix H.

<sup>30</sup> Analyst Note: Award year four (February 1, 2018- January 31, 2019) marked the final year of Delaware’s SIM grant.

<sup>31</sup> Analyst Note: 149th General Assembly, June 2018, SB 236 – Created a one-time appropriation of two million dollars in General Funds to OMB for the development of the Delaware Health Care Claims Database. In order for OMB to disperse the appropriation, the bill outlined provisions that DHIN had to meet. DHIN met the requirements and OMB began the release of funds on or around March of 2019.

<sup>32</sup> Analyst Note: Status of this work is unknown.

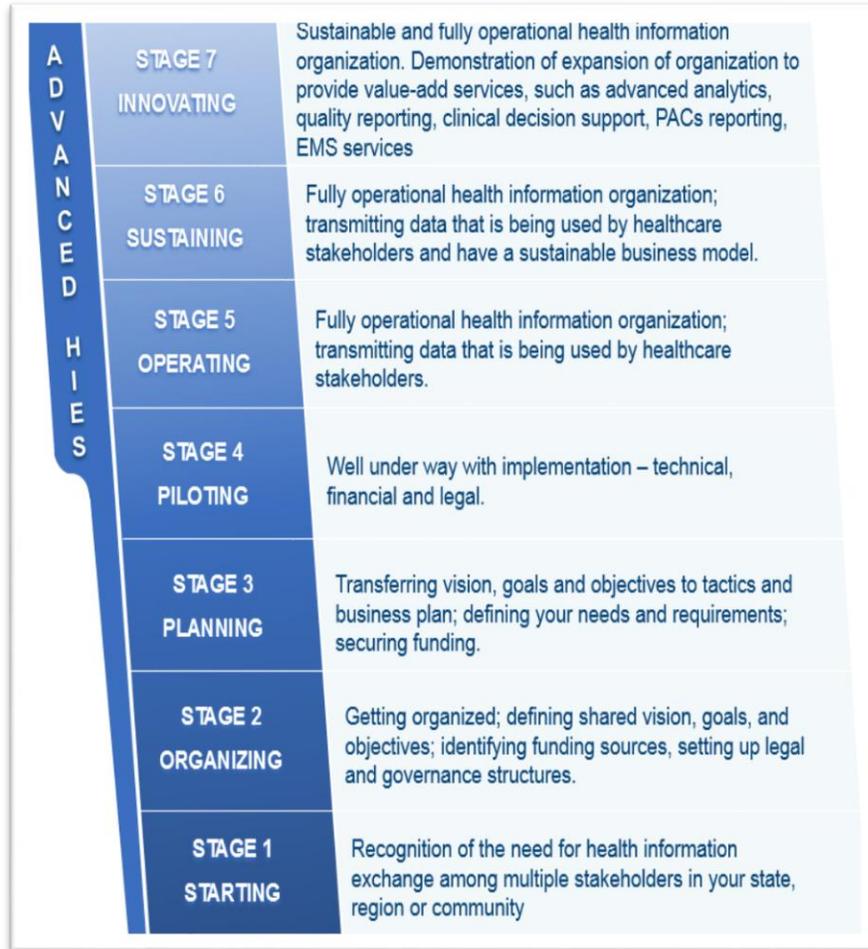
<sup>33</sup> See Appendix F for additional accomplishments.

<sup>34</sup> HITRUST CSF Certified: DHIN Archive, DHINFTPS01, DHIN iSpecimen Prod, Medicity and Managed Infrastructure

<sup>35</sup> per October 2013 Maestro Strategies evaluation of DHIN

<sup>36</sup> per October 2013 Maestro Strategies evaluation of DHIN

- DHIN is a national model of excellence for the development of an effective HIE. On the Advanced HIE Systems Maturity rating scale, DHIN is emerging on Stage 7 as shown below and continues to grow in the provision of statewide critical HIE services and capabilities.<sup>37</sup>



## **CHALLENGES**

A rapidly changing healthcare environment poses challenges to health information exchanges nationwide, and DHIN faces several challenges at both the state level and the national level.

### **Statutory obligations**

DHIN’s evolution through the years has likely caused some confusion at the legislative level, as member of the General Assembly and agency staff may not realize that DHIN is an instrumentality of the State, but does not receive financial assistance for operations from the State.<sup>38</sup>

<sup>37</sup> Analyst Note: Maestro Strategies adapted the rating scale from the eHealth Initiative 2011 report on Health Information Exchange-Sustainability. Maestro Strategies identified DHIN as emerging on stage 7 in their ONC-HIE Final Evaluation Report of DHIN, March 7, 2014.

<sup>38</sup> Analyst Note: DHIN noted in JLOSC questionnaire responses that the Division of Public Health pays DHIN approximately \$44,000 annually for ongoing services provided.

As such, several bills passed by the 148<sup>th</sup> General Assembly affected DHIN’s fiscally by assigning a specific role to DHIN, without funding to undertake the work. Among these:

- 148<sup>th</sup> General Assembly, May 2015, HB 64 – DMOST Act, DHIN to establish a repository for DMOST forms which outline a patient’s end-of-life care preferences.<sup>39</sup>
- 148<sup>th</sup> General Assembly, July 2016, SB 238 – Health Care Claims Database, DHIN to create and maintain the State’s health care claims database, including both clinical and claims data.<sup>40</sup>
- 148<sup>th</sup> General Assembly, July 2016, HB 381 – Pre-Authorizations, DHIN to collect de-identified pre-authorization statistics for approvals, denials and appeals twice a year from insurers, health benefits plans, and health service corporations.<sup>41</sup>
- 148<sup>th</sup> General Assembly, July 2015, SB 58 – Newborn Screening and Genetic Testing, DHIN delivers early hearing detection messages from labs to the Division of Public Health.<sup>42</sup> DHIN was to deliver a packaged report of both the early hearing detection messages, along with accompanying metabolic data to the ordering providers.<sup>43</sup>
- 148<sup>th</sup> General Assembly, August 2016, SB 52 – Lay Caregiver, DHIN to develop and maintain a process to enable a hospital to record the designation of a lay caregiver and the individual’s contact information in the patient’s electronic health record.

DHIN’s efforts to secure funding for the Health Care Claims Database in 2018 demonstrated the need for further education about DHIN’s structure and associated costs for projects. DHIN is willing to take on projects that help Delaware achieve its health outcomes, however, legislation should include the input of the DHIN executive team and the inclusion of a fiscal note (where appropriate) prior to passage.

### **Health Insurer Participation Fees**

Nearly half of DHIN’s revenue stream is funded by the state’s health plans, fees paid for population health related services and access to the community health record. Prior to the 2012 approved merger of Blue Cross Blue Shield of Delaware and Highmark, at DHIN’s request, the Delaware Department of Insurance mandated Highmark pay DHIN one-million dollars per year for five years. That fifth year ended in DHIN’s fiscal year 2018, leaving a one-million dollar revenue gap to overcome going forward.

In addition to the population health subscription services, the payers receive value indirectly from DHIN and its material contributions to the healthcare ecosystem of Delaware and the surrounding region. For example, professional market research studies conducted over a four year period, 2009-2013, showed that DHIN helped reduce the unnecessary duplication of high volume, high cost lab and radiology tests by

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<sup>39</sup> Analyst Note: DMOST Registry is available to authorized users on DHIN’s website. Patient information, DMOST forms, and a patient brochure are also included.

<sup>40</sup> Analyst Note: SB 238 was passed as revenue-neutral; the Health Care Claims Database was created with the intent that it would be funded with grant money and other independent funding sources identified by the DHIN, in accordance with the DHIN’s existing statutory authority.

<sup>41</sup> Analyst Note: Delaware Public Media reported on November 19, 2018 that the Medical Society of Delaware and Haven Health Solutions was working with DHIN to establish a new system called the Smart Prior Authorization Project utilizing medical data already stored by DHIN. It is unknown how this project is funded.

<sup>42</sup> The Division of Public Health pays DHIN for this service.

<sup>43</sup> DHIN indicated this project is on hold.

64% and 22% respectively, which resulted in over ten million dollars in annual savings to the healthcare system in the State. Additionally, a prominent Delaware accountable care organization (“ACO”) credits DHIN’s Event Notification System for reducing 30-day readmission rates for their patients by 12% during a year when the national average increased by 9%. During this period, the same Delaware ACO credits DHIN with helping them reduce emergency room utilization by 6%. It is clear that the regional coordination of results delivery, the elimination of information-sharing barriers between disjointed care delivery systems, and the introduction of innovative tools and services have all served to improve care, efficiencies, and reduce costs. Payers of health insurer participation fees have been reluctant to acknowledge these benefits. As a result, they stand resistant to participating and supporting DHIN financially, which is a threat to DHIN’s long-term self-sustainability.

### **National Landscape**

The ever-changing national health care environment makes planning for the future difficult. The alphabet soup of new federal regulations and incentive programs (TEFCA/MACRA/MIPS)<sup>44</sup> confuses health care providers and leads to a collective change paralysis. Meeting the evolving needs of DHIN’s increasingly diverse membership base is more difficult due to a lack of cohesiveness at the national level.

### **OPPORTUNITIES FOR IMPROVEMENT**

At the heart of DHIN operations, is a continued commitment to demonstrate the value of health information exchange and to create an ecosystem where all participants both contribute and receive value. More specifically, DHIN will continue to build organizational capacity, as recommended as part of the Gartner five-year roadmap.<sup>45</sup> There are five key domains identified for improvement:

- Organizational Capabilities.
- Customer Engagement and Marketing.
- Service Offerings.
- Enterprise and Solution Architecture.
- Service Operations and Management.

Under each domain are a series of initiatives the DHIN team has undertaken to bolster its organizational structure, refine its service offerings, and align all efforts with its strategic direction.

### **ADDITIONAL COMMENT FROM THE COMMITTEE ANALYST**

DHIN listed statutory obligations as a challenge in their JLOSC questionnaire responses. Senate Bill 238 passed by the 148<sup>th</sup> General Assembly in July of 2016, mandated DHIN to create the Health Care Claims Database. Subsequently, the Delaware Health Care Commission entered into a contract with DHIN in order to supply SIM funds to support the creation of the Health Care Claims Database. In reviewing the available State of Delaware SIM fund documents and reports, there were a few mentions to an “assessment” from Freedman Healthcare on the Health Care Claims Database operated by DHIN.<sup>46</sup>

<sup>44</sup> Analyst Note: TEFCA – Trusted Exchange Framework and Common Agreement; MACRA – The Medicare Access and CHIP Reauthorization Act of 2015; MIPS – Merit-based Incentive Payment System

<sup>45</sup> See Appendix G for the strategic roadmap for fiscal years 2017 - 2021

<sup>46</sup> Analyst Note: The Health Care Commission’s website, which includes SIM Initiative information and reports, is located at <https://dhss.delaware.gov/dhcc/sim.html> - SIM quarter one and three reports as well as the SIM Annual Progress Report dated April 30, 2018 specifically mention Freedman Healthcare’s relationship with DHIN.

Specifically, the SIM Annual Progress Report dated April 30, 2018 states:

“In AY3, DHIN promulgated two rules necessary for the reporting of and access to data that will be housed in the HCCD. In addition, DHIN and HCC partnered to request Medicare data through RESDAC. Using SIM support, Freedman Healthcare assessed the level of resources needed to support ongoing operations of the Health Care Claims Database (HCCD). This assessment lays out the level of effort and resources required for DHIN across all tasks, without and with support from Freedman Healthcare.”

After questioning the existence of an assessment report completed by Freedman Healthcare, DHIN provided the contract details between DHIN, the Delaware Health Care Commission, and Freedman Healthcare. Both DHIN and the Delaware Health Care Commission indicated that Freedman Healthcare did not execute or complete an actual assessment report of the Health Care Claims Database.

From the contract details provided, SIM funds for the period of August 1, 2018 through January 31, 2019 provided a maximum of \$1,418,881.31 in funding for the Health Care Claims Database. The SIM Initiative ended on January 31, 2019. DHIN extended a contract with Freedman Healthcare to continue work on the Health Care Claims Database. The contract value between DHIN and Freedman Healthcare for the period of January 25, 2017 through January 31, 2020 is not to exceed \$733,455. Per contract agreement, Freeman Healthcare currently provides ongoing support operations for the Health Care Claims Database at a budgeted amount of \$20,410 per month. The budgeted amount for monthly DHIN support operations of the database is unknown.

Since SIM funds had a projected end of January 31, 2019, the 149<sup>th</sup> General Assembly, passed Senate Bill in June of 2018, which created a one-time appropriation of two million dollars in General Funds to further support the Health Care Claims Database. The current functionality status and the exact amount of resources needed to continue Health Care Claims Database operations are unknown.

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**APPENDIX A**

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**TITLE 16****Health and Safety****Delaware Health Information Network****CHAPTER 103. DELAWARE HEALTH INFORMATION NETWORK****Subchapter I. Purpose, Power and Duties, and other Governing Provisions of the Delaware Health Information Network**

## § 10301 Purpose.

(a) The purpose of this chapter is to create a public instrumentality of this State known as the Delaware Health Information Network ("DHIN") which is a not-for-profit body both politic and corporate, which shall have the rights, obligations, privileges, and purpose to promote the design, implementation, operation, and maintenance of facilities for public and private use of health care information in the State. The DHIN shall be the State's sanctioned provider of health information exchange services.

(b) It is intended that the DHIN be a public-private partnership for the benefit of all of the citizens of this State.

(c) The DHIN shall ensure the privacy of patient health-care information.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, §§ 1, 16; 80 Del. Laws, c. 329, §§ 1, 2.;

## § 10302 Creation of Delaware Health Information Network.

(a) There is hereby established the Delaware Health Information Network, which will be managed and operated by a Board of Directors consisting of 19 members. It is intended that the membership of the Board include individuals with various business, technology and healthcare industry skills committed to managing the Corporation in an efficient, effective and competitive manner. The Board shall be comprised of the following members:

- (1) The Director of the Office of Management and Budget or the Director's designee;
- (2) The Chief Information Officer of the Department of Technology and Information or the Chief Information Officer's designee;
- (3) The Secretary of the Department of Health and Social Services or the Secretary's designee;
- (4) The Controller General or the Controller General's designee;
- (5) Six members, appointed by the Governor, including at least 1 person who shall represent the interests of medical consumers and at least 3 with experience and/or expertise in the health-care industry;
- (6) Three members appointed by the Governor representing hospitals or health systems;
- (7) Three members appointed by the Governor representing physicians;
- (8) One member appointed by the Governor representing businesses or employers; and
- (9) Two members appointed by the Governor representing health insurers or health plans.

The Chair of the Board shall be elected from among its members by a majority of the Directors and shall serve a 3-year term. Each member shall serve a 3-year term, with such initial terms being staggered as set by the

Governor and each member continuing to serve beyond such term until a successor is appointed. Any member absent without adequate reason for 3 consecutive meetings, or who fails to attend at least half of all regular business meetings during any calendar year, may be removed from the Board with the approval of the Governor upon a recommendation from the Board. The Board, the Delaware Healthcare Association, the Medical Society of Delaware, Delaware State Chamber of Commerce, and other interested organizations may make nonbinding recommendations to the Governor for appointments to the Board.

(b) No state officer or employee appointed to the Board or serving in any other capacity for the Board shall be deemed to have resigned from public office or employment by reason of such appointment or service. Members of the Board who are serving on January 1, 2011, shall continue to serve until a successor is appointed by the Governor or otherwise designated by the ex officio members.

(c) The Board is authorized to conduct its business by a majority of a quorum. A quorum is a simple majority of the members appointed.

71 Del. Laws, c. 177, § 1; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 88, § 21(8); 75 Del. Laws, c. 389, § 1; 77 Del. Laws, c. 368, §§ 2-5, 16; 80 Del. Laws, c. 329, § 1.;

§ 10303 Powers and duties.

(a) In furtherance of the purposes of this chapter, the DHIN shall have the following powers and duties:

(1) Develop and maintain a community-based health information network to facilitate communication of patient clinical and financial information, designed to:

- a. Promote more efficient and effective communication among multiple health care providers, including, but not limited to, hospitals, physicians, payers, employers, pharmacies, laboratories and other health care entities;
- b. Create efficiencies in health-care costs by eliminating redundancy in data capture and storage and reducing administrative, billing and data collection costs;
- c. Create the ability to monitor community health status; and
- d. Provide reliable information to health-care consumers and purchasers regarding the quality and cost-effectiveness of health care, health plans and health-care providers;

(2) Develop or design other initiatives in furtherance of its purpose;

(3) Report and make recommendations to the Governor and General Assembly;

(4) Adopt bylaws to govern the conduct of its affairs and to carry out and discharge its powers, duties and functions and to adopt policies as appropriate to carry out and discharge its powers, duties, and functions, and to sue, but not be sued, to enter into contracts and agreements and to plan, control facilities and such real and personal property as it may deem necessary, convenient or desirable without applications of the provisions of Chapter 59, 69, or 70 of Title 29;

(5) All prior regulations and rules promulgated by the Delaware Health Care Commission regarding the DHIN shall remain in full force and effect until the DHIN replaces the aforementioned regulations and rules with bylaws and/or policies;

(6) The bylaws shall include a provision pertaining to conflicts of interest and that Board members, staff, committee members and others conducting business or associated with the DHIN shall be required to sign conflict of interest statements;

(7) To have and exercise any and all powers available to a corporation organized pursuant to Chapter 1 of Title 8, the Delaware General Corporation Law;

- (8) To employ such personnel and provide such benefits as necessary to carry out its functions and to retain by contract engineers, advisors, and other providers of advice, counsel and services which it deems advisable or necessary in the exercise of its purposes and powers and upon such terms as it deems appropriate;
- (9) To exercise all of the power and the authority with respect to the operation, development and maintenance of the DHIN;
- (10) To do all acts and things necessary or convenient to carry out its functions, including without limitation, the authority to open and operate separate bank accounts in the name of the DHIN;
- (11) To collect, receive, hold and disburse funds in accordance with the needs of the DHIN, including user fees set by the DHIN;
- (12) Implement and operate a statewide integrated health information network to enable communication of clinical and financial health information, and other information and other related functions as deemed necessary by the Board;
- (13) Promote efficient and effective communication among Delaware healthcare providers and stakeholders including hospitals, physicians, state agencies, payers, employers, and laboratories;
- (14) Promote efficiencies in the healthcare delivery system;
- (15) Provide a reliable health information exchange to authorized users;
- (16) Work with governments and other states to integrate into or with the DHIN and/or assist them in providing regional integrated health information systems;
- (17) Work towards improving the quality of health care and the ability to monitor community health status and facilitate health promotions by providing immediate and current outcome, treatment and cost data and related information so that patients, providers and payers can make informed and timely decisions about health care;
- (18) Make annual reports to the Governor and members of the General Assembly setting forth in detail its operations and transactions, which shall include annual audits of the books and accounts of the DHIN made by a firm of independent certified public accountants mutually agreed to by the Auditor of Accounts and the Director of the Office of Management and Budget;
- (19) Develop and maintain a process to enable a hospital to record in the patient's electronic health record contained in the DHIN the patient's designation of a lay caregiver and the lay caregiver's contact information, as required by § 3002J(b) of this title, and if the hospital attempted to or did interface with the lay caregiver, as required by § 3004J(b) of this title;
- (20) Develop, maintain, and administer the Delaware Health Care Claims Database under subchapter II of this chapter; and
- (21) Perform any and all other activities in furtherance of this section.

(b) To carry out the above duties, the DHIN is granted all incidental powers, without limitation, including the following:

- (1) To contract with sufficient third parties and/or employ nonstate employees, without applications of the provisions of Chapter 59, 69, or 70 of Title 29 respectively;
- (2) To establish a nonappropriated special funds account in its budget in order to receive gifts and donations;
- (3) To establish reasonable fees or charges for provision of its services to nonparticipant third parties; and

(4) To sell or license any copyrighted or patented intellectual property.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, §§ 6-8, 16; 80 Del. Laws, c. 329, §§ 1, 3; 80 Del. Laws, c. 347, § 3.;

§ 10304 Immunity from suit; limitation of liability.

(a) All members of the Board of Directors of the DHIN, whether temporary or permanent, shall not be subject to and shall be immune from claim, suit, liability, damages or any other recourse, civil or criminal, arising from any act or proceeding, decision or determination undertaken, performed or reached in good faith and without malice by any such member or members acting individually or jointly in carrying out the responsibilities, authority, duties, powers and privileges of the offices conferred by law upon them under this chapter, or any other state law, or duly adopted rules and regulations of the DHIN, good faith being presumed until proven otherwise, with malice required to be shown by a complainant. All employees and staff of the DHIN, whether temporary or permanent, shall enjoy the same rights and privileges concerning immunity from suit otherwise enjoyed by state employees pursuant to the Constitution of this State and §§ 4001 through 4005 of Title 10.

(b) The DHIN is not a health-care provider and is not subject to claims under Chapter 68 of Title 18. No person or entity who participates or subscribes to the services or information provided by the DHIN shall be liable in any action for damages or costs of any nature, in law or equity, which result solely from that person's use or failure to use DHIN information or data that was imputed or retrieved in accordance with the rules or regulations of the DHIN. In addition, no person shall be subject to antitrust or unfair competition liability based on membership or participation in the DHIN as the State's sanctioned provider of health information services that are deemed to be essential to governmental function for the public health and safety.

71 Del. Laws, c. 177, § 1; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 368, §§ 9, 10, 16; 80 Del. Laws, c. 329, § 1.;

§ 10305 Property rights.

(a) All persons providing information and data to the DHIN shall retain a property right in that information or data, but grant to the other participants or subscribers a nonexclusive license to retrieve and use that information or data in accordance with the rules or regulation promulgated by the DHIN.

(b) All processes or software developed, designed or purchased by the DHIN shall remain its property subject to use by participants or subscribers in accordance with the rules or regulations promulgated by the DHIN.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, §§ 11, 16; 80 Del. Laws, c. 329, § 1.;

§ 10306 Regulations; resolution of disputes.

(a) The DHIN may promulgate rules and regulations under subchapter II of Chapter 101 of Title 29 to carry out the objective of this chapter. All prior regulations and rules promulgated by the Delaware Health Care Commission in regards to the DHIN shall remain in full force and effect until amended or repealed by the DHIN.

(b) To resolve disputes under this chapter, or the rules and regulations promulgated under this chapter, among participants, subscribers, or the public, the DHIN may hear and determine case decisions under subchapter III of Chapter 101 of Title 29.

(c) Any person aggrieved by the unlawfulness of any rule or regulation of the DHIN herein, or any person against whom a case decision has been decided, may appeal to the Superior Court in accordance with subchapter V of Chapter 101 of Title 29.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, §§ 12, 13, 16; 80 Del. Laws, c. 329, §§ 1, 4.;

§ 10307 Privacy; protection of information.

- (a) The DHIN shall by rule or regulation ensure that patient specific health information be disclosed only in accordance with the patient's consent or best interest to those having a need to know.
- (b) The health information and data of the DHIN shall not be subject to the Freedom of Information Act, Chapter 100 of Title 29, nor to subpoena by any court. Such information may only be disclosed by consent of the patient or in accordance with the DHIN's rules, regulations or orders.
- (c) Any violation of the DHIN's rules or regulations regarding access or misuse of the DHIN health information or data shall be reported to the office of the Attorney General, and subject to prosecution and penalties under the Delaware Criminal Code or federal law.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, §§ 14, 16; 80 Del. Laws, c. 329, § 1.;

§ 10308 No pledge of state credit; no assumption of liability by State.

The DHIN shall have no power, except where expressly granted by separate act of the General Assembly, to pledge the credit or to create any debt or liability of the State or of any other agency or of any political subdivision of the State, and the State shall not assume or be deemed to have assumed any debt or liability of the DHIN as a result of any actions by the DHIN.

71 Del. Laws, c. 177, § 1; 77 Del. Laws, c. 368, § 16; 80 Del. Laws, c. 329, § 1.;

## **TITLE 16**

### **Health and Safety**

#### **Delaware Health Information Network**

#### **CHAPTER 103. DELAWARE HEALTH INFORMATION NETWORK**

##### **Subchapter II. The Delaware Health Care Claims Database**

§ 10311 The Delaware Health Care Claims Database — Findings; purpose; creation.

(a) The General Assembly finds that:

- (1) The establishment of effective health-care data analysis and reporting initiatives is essential to achieving the "Triple Aim" of the State's ongoing health-care innovation efforts: improved health, health-care quality and experience, and affordability for all Delawareans.
- (2) The ongoing work of the Delaware Center for Health Innovation to transform the State's health-care system from a fee-for-service system to a value-based system that rewards health-care providers for quality and efficiency of care is a worthy effort, and, to that end, the General Assembly supports the establishment of a health-care claims database that would assist in the State's efforts to achieve the Triple Aim.
- (3) Claims data is an important component of population health research and analysis, and that appropriate access to claims data can facilitate the development of value-based health-care purchasing and the study of the prevalence of illness or injury across the broader population of Delaware and in particular communities or neighborhoods.
- (4) Providers and other health-care entities accepting financial risk for managing the health-care needs of a population, including the State as a self-insured employer, should have access to claims data as necessary to effectively manage that risk.

(b) The purpose of this subchapter is to create a centralized health-care claims database to enable the State to more effectively understand utilization across the continuum of health care in Delaware and achieve the Triple Aim.

(c) The DHIN, assisted by the Department of Health and Social Services and the Delaware Health Care Commission as necessary, shall administer a centralized health-care claims database, known as the "Delaware Health Care Claims Database."

(d) The Delaware Health Care Claims Database is created within the DHIN to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through increased transparency of accurate health-care claims data and information. The DHIN shall collect and maintain claims data under this subchapter.

80 Del. Laws, c. 329, § 5.;

§ 10312 Definitions.

For purposes of this chapter, unless amended, supplemented, or otherwise modified by regulations adopted under this chapter:

- (1) "Claims data" includes required claims data and any additional health-care claims information that a voluntary reporting entity elects, through entry into an appropriate data submission and use agreement under this subchapter, to submit to the Delaware Health Care Claims Database.
- (2) "Health-care services" means as defined in § 6403 of Title 18.
- (3) "Health insurer" means as defined in § 4004 of Title 18. "Health insurer" does not include providers of casualty insurance, as defined in § 906 of Title 18; providers of group long-term care insurance or long-term care insurance, as defined in § 7103 of Title 18; or providers of a dental plan or dental plan organization, as defined in § 3802 of Title 18.
- (4) "Mandatory reporting entity" means all of the following entities, to the extent permitted under federal law:
  - a. The State Employee Benefits Committee and the Office of Management and Budget, under each entity's respective statutory authority to administer the State Group Health Insurance Program in Chapter 96 of Title 29, and any health insurer, third-party administrator, or other entity that receives or collects charges, contributions, or premiums for, or adjusts or settles health claims for, any State employee, or their spouses or dependents, participating in the State Group Health Insurance Program, except for any carrier, as defined in § 5290 of Title 29, selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under Chapter 52C of Title 29.
  - b. The Division of Medicaid and Medical Assistance, with respect to services provided under programs administered under Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq. and 1397aa et seq.].
  - c. Any health insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year, except for any health insurer or other entity that is not otherwise required to provide claims data as a condition of certification as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year.
  - d. Any federal health insurance plan providing health-care services to a resident of this State, including Medicare and the Federal Employees Health Benefits Plan.
  - e. Any health insurer providing health-care coverage to a resident of this State.

(5) "Pricing information" includes the preadjudicated price charged by a provider or facility to a reporting entity for health-care services, the amount paid by a patient or insured party, including copays and deductibles, and the postadjudicated price paid by a reporting entity to a provider for health-care services.

(6) "Provider" means a hospital or any health-care practitioner licensed, certified, or authorized under state law to provide health-care services and includes hospitals and health-care practitioners participating in group arrangements, including accountable care organizations, in which the hospital or health-care practitioners agree to assume responsibility for the quality and cost of health care for a designed group of beneficiaries.

(7) "Reporting date" means a calendar deadline, to be scheduled on a regularly recurring basis, by which required claims data must be submitted by a mandatory reporting entity to the Delaware Health Care Claims Database.

(8) "Required claims data" includes the basic claims information that a mandatory reporting entity is required to submit to the Delaware Health Care Claims Database by the reporting date, including all of the following:

- a. Basic demographic information, including the patient's gender, age, and geographic area of residency.
- b. Basic information relating to an individual episode of care, including the date and time of the patient's admission and discharge; the identity of the health-care services provider; and the location and type of facility, such as a hospital, office, or clinic, where the service was provided.
- c. Information describing the nature of health-care services provided to the patient in connection with the encounter, visit, or service, including diagnosis codes.
- d. Health insurance product type, such as HMO or PPO.
- e. Pricing information.

(9) "Third-party administrator" means as defined in § 102 of Title 18.

(10) "Voluntary reporting entity" includes, except as prohibited under applicable federal law, any of the following entities, unless such entity is a mandatory reporting entity:

- a. Any health insurer.
- b. Any third-party administrator.
- c. Any entity, which is not a health insurer or third-party administrator, when such entity receives or collects charges, contributions, or premiums for, or adjusts or settles health-care claims for, residents of this State.

80 Del. Laws, c. 329, § 5; 81 Del. Laws, c. 79, § 32; 81 Del. Laws, c. 392, § 3.;

§ 10313 Submission of required claims data by mandatory reporting entities; submission of claims data by voluntary reporting entities.

(a) Requirements for submission of required claims data by a mandatory reporting entity.

(1) A mandatory reporting entity shall submit required claims data to the Delaware Health Care Claims Database by the reporting date.

(2) The DHIN, subject to the provisions of this subchapter and regulations promulgated under this subchapter, shall collect the required claims data from mandatory reporting entities by the reporting date.

(3) The DHIN shall, under § 10306 of this title, promulgate a template form for a data submission and use agreement for the submission of required claims data by a mandatory reporting entity.

(4) The DHIN and each mandatory reporting entity shall execute a mutually acceptable data submission and use agreement. Such agreement shall include procedures for submission, collection, aggregation, and distribution of claims data and shall provide for, at a minimum, all of the following:

- a. The protection of patient privacy and data security under provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act [P.L. 104-191]; Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq. and 1397aa et seq.]; and the Health Information Technology for Economic and Clinical Health (HITECH) Act [42 U.S.C. §§ 300jj et seq. and 17901 et seq.], and all other applicable state and federal laws relating to the privacy and security of protected health information.
- b. The identification of any claims data, in addition to required claims data, that the mandatory reporting entity elects to submit to the Delaware Health Care Claims Database.
- c. A detailed summary of how claims data submitted by the mandatory reporting entity may be used for geographic, demographic, economic, and peer group comparisons.
- d. A representation and warranty that the DHIN shall, abide to the fullest extent possible, by nationally recognized data collection standards and methods, including the standards promulgated by the APCD Council or successor organization, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various health-care claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis.

*(5) Exclusions from required claims data reporting requirement. — The required claims data reporting requirements under this subchapter, and any rules and regulations promulgated under this chapter, do not apply to required claims data created for any employee welfare benefit plan or other employee health plan that is regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq., unless otherwise permitted by federal law or regulation.*

(b) *Submission of claims data by a voluntary reporting entity. —*

- (1) The DHIN shall collect claims data from voluntary reporting entities under the terms and conditions of the applicable data submission and use agreement.
- (2) The DHIN may promulgate regulations to clarify the types of claims data that may be submitted by a voluntary reporting entity.
- (3) The DHIN and any voluntary reporting entity that elects to submit claims data to the Delaware Health Care Claims Database shall execute a mutually acceptable data submission and use agreement. The DHIN shall publish a template form data submission and use agreement that includes the required data submission and use agreement provisions under paragraph (a)(4) of this section.

(c) Unless modified or supplemented by regulations promulgated under this chapter, in instances where more than 1 entity is involved in the administration of a policy, a health insurer shall be responsible for submitting the claims data on policies that it has written, and the third-party administrator shall be responsible for submitting claims data on self-insured plans that it administers.

80 Del. Laws, c. 329, § 5.;

§ 10314 External and public reporting of claims data.

(a) The DHIN shall provide Delaware health-care payers, providers, and purchasers with access to the Delaware Health Care Claims Database for the purpose of facilitating the design and evaluation of alternative delivery and payment models, including population health research and provider risk-sharing arrangements.

- (1) Claims data provided to the Delaware Health Care Claims Database shall only be provided to a requesting party when a majority of the DHIN Board of Directors, or of a subcommittee established under

the DHIN's bylaws for purposes of administering the Health Care Claims Database, determines that the claims data should be provided to the requesting party to facilitate the purposes of this subchapter or to the Delaware Health Care Commission.

a. The determination under this paragraph (a)(1) shall be reduced to writing and provided to the requesting party.

b. The determination under this paragraph (a)(1) shall be final and not subject to appeal, and there is no private right of action to a requesting party against the DHIN or any other party to enforce the requirements of this section.

(2) The DHIN shall, in consultation with the Delaware Health Care Commission, promulgate rules and regulations regarding the appropriate form and content of an application to receive claims data, providing examples of requests for claims data that will generally be deemed consistent with the purposes of this subchapter.

(b) Claims data provided to a requesting party under this section shall be provided under the DHIN's existing confidentiality and data security protocols and in compliance with all applicable state and federal laws relating to the privacy and security of protected health information, including compliance, to the fullest extent practicable consistent with the purposes under this subchapter, with guidance found in Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information. Individually identifiable patient health information shall be maintained by providers and purchasers in accordance with all applicable state and federal laws relating to the confidentiality and security of protected health information and any additional privacy and security requirements set forth in regulations promulgated under this chapter.

(c) The Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, and Division of Medicaid and Medical Assistance shall have access to all claims data reported by the Delaware Health Care Claims Database under this subchapter at no cost for the purposes of public health improvement research and activities. These entities are authorized to enter into appropriate agreements with the DHIN to allow the Delaware Health Care Claims Database to perform data warehousing and analytics functions that have been performed pursuant to the existing statutory authority of the Office of Management and Budget, the State Employee Benefits Committee, or the Department of Health and Social Services.

(d) The DHIN may promulgate regulations to make available to the public certain nonindividually identifiable data extracts and analyses, as the DHIN determines is consistent with, and necessary to, achieve the goals and policies of this subchapter. Prior to the release of such data extracts and analyses, the same processes identified in subsection (e) of this section shall be completed.

(e) The DHIN shall promulgate regulations to notify a mandatory reporting entity or voluntary reporting entity when claims data submitted by the mandatory reporting entity or voluntary reporting entity may be released for a purpose permitted under this subchapter and provide the mandatory reporting entity or voluntary reporting entity with an opportunity to comment on the data release request prior to its release. Any comments received from a mandatory reporting entity or voluntary reporting entity during the comment period shall be reviewed, considered, and responded to by DHIN prior to the data release. If a party requesting the release of data is identified by a mandatory reporting entity or voluntary reporting entity as a potential competitor of the reporting entity, the DHIN shall limit disclosure of any pricing information that includes postadjudicated claims data, to the fullest extent practicable and consistent with the purposes of this subchapter, to a summary format that allows for analysis without revealing contracted pricing information.

(f) The DHIN shall promulgate regulations to ensure confidentiality, privacy, and security protections of health-care data and all other information collected, stored, or released by DHIN, subject to all applicable state and federal health-care privacy, confidentiality, and data security laws.

§ 10315 Funding of Delaware Health Care Claims Database.

(a) The DHIN may not require any mandatory reporting entity, voluntary reporting entity, or provider to pay any cost or fee to submit or verify the accuracy of claims data or otherwise to enable the operation of the Delaware Health Care Claims Database with respect to required claims data submissions.

(b) The DHIN may enter contracts under § 10303(a)(11) of this title with individuals and entities who voluntarily subscribe to access the database.

(c) The DHIN, with the assistance of the Department of Health and Social Services, shall develop short-term and long-term funding strategies for the creation and operation of the Delaware Health Care Claims Database that may include public and private grant funding, subscriptions for access to data reports, access fees, and revenue for specific data projects, subject to the limitations of this section.

80 Del. Laws, c. 329, § 5.;

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## **APPENDIX B**

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### **101 Delaware Health Information Network Regulations**

#### **1.0 Board of Governance and Administration**

##### 1.1 Appointment; Terms of Office

1.1.1 Individuals appointed to the Board of the Delaware Health Information Network (hereafter "Board") shall be appointed in writing by the entity holding the power of appointment pursuant to 16 **Del.C.** §9921. The appointing entity may remove any of its appointees by appointing another with at least thirty days notice to the Chairperson of the Board.

1.1.2 Individuals shall be appointed to the Board for a term of three years, except as provided herein. The term for each Board position shall be staggered by thirds, more or less, so that the first term for a Board position may be one, two or three years and shall be determined by lot. The Secretary shall maintain a record of the terms for each Board position. Terms shall commence on January 1 and expire on December 31 of the appropriate year and upon appointment of their successors.

1.1.3 A member of the Board may be removed for cause by the majority of the members appointed to the Board and confirmed by the Delaware Health Care Commission.

##### 1.2 Officers of the Board; Duties

1.2.1 One member of the Board shall be elected to serve as Chairperson by a majority of the members appointed to the Board. The Chairperson shall:

1.2.1.1 preside over meetings of the Board;

1.2.1.2 maintain good order;

1.2.1.3 determine the agenda for meetings

1.2.1.4 appoint the membership of committees and work groups, except the Executive Committee;

1.2.1.5 execute documents in the name of the Board; and

1.2.1.6 perform such other matters as determined by the Board.

1.2.2 One member of the Board shall be elected to serve as Vice-Chairperson by a majority of the members appointed to the Board. The Vice-Chairperson shall perform the duties of the Chairman when he or she is not able to do so.

1.2.3 One member of the Board shall be elected to serve as Secretary by a majority of the members appointed to the Board. The Secretary shall maintain the records of the Board and its members, and attest to the official matters of the Board. Additionally, the Secretary shall perform the duties of the Chairman when the Chairperson and Vice-Chairperson are not able to do so.

### 1.3 Committees, Work Groups

1.3.1 The Board shall have an Executive Committee and such other committees or work groups as may be desirable from time to time. A member of the Board shall serve as the Chairperson of such committees. The Executive Committee shall be comprised of 7 members, to include the Chairperson, who shall preside, the Vice-Chairperson, the Secretary and 4 other members elected by a majority of the Board. The Executive Committee is authorized to act on behalf of the full Board where the full Board can not be reasonably convened to act in a timely manner on a matter, as assigned by the Board.

1.3.2 No Committee, except the Executive Committee, or work group needs a quorum to conduct business. Nevertheless, such meetings shall be conducted publicly, unless the meeting is determined to be closed to the public.

1.3.3 Meetings and activities of committees and work groups shall be determined by the committee and group leadership, and in accordance with the direction of the Board.

### 1.4 Board Meetings; Notice

1.4.1 The Chairperson, with the advice of the Board, shall determine the frequency and schedule of Board meetings and with the assistance of the staff provide the required notices pursuant to 29 Del.C., Ch. 100.

1.4.2 A majority of the members of the Board shall constitute a quorum and shall be sufficient for any action by the Board provided, however, that if the number afterwards should be reduced below a quorum, business is not interrupted unless a member calls attention to the fact.

1.4.3 The Board may convene special meetings or reschedule meetings as provided by law.

1.4.4 All meetings of the Board shall be conducted in public unless it is closed to the public in accordance with law.

### 1.5 Public Access to Records

1.5.1 The Board shall permit access to its public records in accordance with the law and as that term is defined in 29 Del.C., Ch. 100. A Delaware citizen that wishes to inspect the Board's public records shall call or write to staff to determine a convenient time and place. The Board may impose a reasonable charge for requested copying of any public records. The Chairperson may request legal advice from the Attorney General and authorize access to public records.

1.5.2 No access shall be provided to the health information network or data without an order of the Health Care Commission or otherwise in accordance with these rules.

### 1.6 Conflict of Interest; Recusal

1.6.1 The members shall conduct themselves in accordance with the Delaware Code of Ethics, 29 Del.C., Ch. 58.

1.6.2 If any member has a conflict of interest as defined in the Code of Ethics, they shall recuse themselves from voting in the matter. The conflicted members may participate in discussions on the conflicted matter as long as they have disclosed the nature of the conflict to the other members. If they choose not to disclose the nature of the conflict to the other members, such conflicted members must publicly state at the Board meeting or in writing to the Chairperson they will not be participating in the conflicted matter. The Secretary shall maintain a record of such recusals.

1.6.3 Members may seek legal advice on purported conflicts from the Attorney General or a determination from Ethics Counsel.

## 1.7 Statutory Authority

1.7.1 The Delaware Health Care Commission is authorized pursuant to 16 Del.C. §9925(a) to promulgate these rules in accordance with 29 Del.C., Ch. 101.

2 DE Reg. 2046 (5/1/99)

# 102 Delaware Health Information Network Regulations on Participation

## 1.0 Statutory Authority

This regulation is authorized by 16 Del.C. §§ 9925 and 9926.

1.1 The Delaware Health Information Network ["DHIN"] was created by statute, 16 Del.C. Ch. 99, Subchapter IV, to be a public instrumentality of the State of Delaware to promote the design, implementation, operation and maintenance of facilities for public and private use of health care information. The DHIN is operated through a Board of Directors. In keeping with the purpose, it is now more convenient to promulgate a regulation that will provide the requirements of participation in the DHIN and replace the numerous written documents among the participants and the DHIN. The regulation also seeks to clarify the obligations, requirements, permitted use and privacy of data for the participants.

1.2 As use in this regulation, the term "DHIN" refers to the entity unless the context refers to the electronic interchange system operated and maintained by the entity. Unless otherwise required any action by the entity shall be by majority vote of the quorum of the present members of the Board of Directors ["Board"]. Meetings of the Board may include members that are participating electronically or telephonically, as long as the public can hear or observe the participation of such members.

## 2.0 Participation and withdrawal.

2.1 Participation in the DHIN is voluntary and is commenced by filing with the Executive Director ["Director"] of the DHIN a document that is known as an application for participation agreement ["Application"]. The Application shall: identify the individual or entity in detail, provide its healthcare activity and purpose, identify the individual or individuals that have the authority to bind the entity and conduct its business affairs, and include such other information as may be required by the Board. The Participation agreement shall also contain a statement that the entity agrees to be bound without reservation by this and other regulations, policies and/or procedures that involve the DHIN.

2.2 The participation agreement along with other information that may be reasonable as determined by the Director and the Executive Committee ["Committee"] of the Board shall be reviewed by the Director and the Committee to their satisfaction. The Executive Committee may request additional information or may grant initial participation to the applying entity subject to certain conditions. The initial participation determination is subject to a subsequent ratification by the Board. If no action is taken by the Board during its next two regular meetings with a quorum present, the Board is deemed to have ratified the initial participation of the applying entity. If the Committee denies initial participation to an applying entity, it will provide the reason or reasons for denial. After such denial, the applying entity may request the Board reconsider the Committee's denial. If the Board denies reconsideration, the applying entity may then seek legal review in accordance with 29 Del.C. Ch. 101, Subchapter V.

2.3 Withdrawal from participation is commenced by filing with the Director and the Committee a document that is known as notice of withdrawal. The Board will determine the specific information and other requirements that will be contained in the notice of withdrawal. The Director, the Committee and the withdrawing entity shall seek agreement as to the effective date of withdrawal and any other reservations or conditions. If the parties cannot agree, the Committee with the subsequent ratification of the Board shall determine the effective date of withdrawal and any other conditions or reservations of the withdrawal.

2.4 Participation may be involuntarily terminated due to security or privacy breaches or failure or refusal to perform obligations of participation. Involuntary termination shall be subject to the procedures for dispute resolution contained below.

### **3.0 Privacy and security of personal health care information and obligations of participants:**

3.1 The participants of the DHIN may have roles that functionally vary from transaction to transaction. A participant may be a "Covered Entity" or a "Business Associate", as those terms are defined in the HIPAA Regulations, in regards to different transactions with different participants. It is desirable to import the obligations of the participants under Health Insurance Portability and Accountability Act of 1996, and regulations promulgated there under ("HIPAA Regulations"), including the Standards for Privacy of Individually Identifiable Health Information and Security Regulations, 45 Code of Federal Regulations Parts 160, 162 and 164 ("Regulations"). The importation of the participants' obligations under HIPAA is more efficient than requiring numerous written documents with the possibility of omitting such a required document. Accordingly, each participant agrees to be bound as follows:

3.1.1 Definitions. As used in this section the following terms are defined as follows:

**"Disclose"** and **"Disclosure"** mean, with respect to Health Information, the release, transfer, provision of, access to, or divulging in any other manner of Health Information outside Business Associate's internal operations or to other than its employees.

**"Health Information"** means information that (i) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; (ii) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual); and (iii) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity.

**"Security Incident"** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

**"Use"** or **"Uses"** mean, with respect to Health Information, the sharing, employment, application, utilization, examination or analysis of such Health Information within Business Associate's internal operations.

### 3.2 Obligations of Business Associate

3.2.1 Initial Effective Date of Performance. The obligations created under this section are effective upon initial participation in the DHIN.

3.2.2 Permitted Uses and Disclosures of Health Information. Business Associate shall Use and Disclose Health Information as necessary to perform services for Covered Entity, provided that such Use or Disclosure would not violate the Privacy Regulations if done by Covered Entity. Business Associate may Use and Disclose Health Information for the proper management and administration of Business Associate, or to carry out the legal

responsibilities of the Business Associate, provided that the disclosure is required by law, or the Business Associate obtains reasonable assurances in writing from the person to whom the information is disclosed that: (i) that it will be held confidentially and used or further disclosed only for the purpose for which it was disclosed; and (ii) the person is obligated to notify Business Associate (who will notify Covered Entity) of any instances of which it is aware in which the confidentiality of the information has been breached.

3.2.3 Adequate Safeguards for Health Information. Business Associate warrants that it shall implement and maintain appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity and to prevent the Use or Disclosure of Health Information in any manner other than as permitted by this Agreement.

3.2.4 Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Health Information by Business Associate in violation of the requirements of this Agreement.

3.2.5 Reporting Non-Permitted Use or Disclosure. Business Associate shall report to Covered Entity each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors that is not specifically permitted by this Agreement. The initial report shall be made by telephone call to Covered Entity's Privacy Officer within forty-eight (48) hours from the time the Business Associate becomes aware of the non-permitted Use or Disclosure, followed by a written report to the Privacy Officer no later than five (5) days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure. Business Associate shall report to Covered Entity any security incident of which it becomes aware.

3.2.6 Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Health Information available to the Covered Entity, or at the request of Covered Entity, to the Secretary of the U.S. Department of Health and Human Services ("Secretary"), in a time and manner designated by the Covered Entity or the Secretary, for purposes of determining Covered Entity's compliance with the Privacy Regulations.

3.2.7 Access to and Amendment of Health Information. Business Associate shall, to the extent Covered Entity determines that any Health Information constitutes a "designated record set" under the Privacy Regulations, (a) make the Health Information specified by Covered Entity available to the individual(s) identified by Covered Entity as being entitled to access and copy that Health Information, and (b) make any amendments to Health Information that are requested by Covered Entity. Business Associate shall provide such access and make such amendments within the time and in the manner specified by Covered Entity.

3.2.8 Accounting of Disclosures. Upon Covered Entity's request, Business Associate shall provide to Covered Entity an accounting of each Disclosure of Health Information made by Business Associate or its employees, agents, representatives or subcontractors as required by the Privacy Regulations. Any accounting provided by Business Associate under this Section 3.2.8 shall include: (a) the date of the Disclosure; (b) the name, and address if known, of the entity or person who received the Health Information; (c) a brief description of the Health Information disclosed; and (d) a brief statement of the purpose of the Disclosure. For each Disclosure that requires an accounting under this Section 3.2.8, Business Associate shall track the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

3.2.9 Restrictions: Requests for Confidential Communications. Business Associate will comply with any agreements for confidential communications of which it is aware and to which Covered Entity agrees pursuant to 45 C.F.R. §164.522 (b) by communicating with individuals using agreed upon alternative means or alternative locations.

3.2.10 Disposition of Health Information Upon Termination or Expiration. Upon termination or expiration of this Agreement, Business Associate shall either return or destroy, in Covered Entity's sole discretion and in accordance with any instructions by Covered Entity, all Health Information in the possession or control of Business Associate and its agents and subcontractors. However, if Covered Entity determines that neither return nor destruction of Health Information is feasible, Business Associate may retain Health Information provided that Business Associate (a) continues to comply with the provisions of this Agreement for as long as it retains Health Information, and (b) further limits Uses and Disclosures of Health Information to those purposes that make the return or destruction of Health Information infeasible.

3.2.11 Term and Termination. Unless sooner terminated, this Agreement shall continue in effect so long as Business Associate continues to provide services or perform functions on behalf of Covered Entity. A material breach by Business Associate of any provision of this Agreement, as determined by Covered Entity, shall constitute a material breach of the Agreement providing grounds for immediate termination of this Agreement. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may provide an opportunity for Business Associate to cure the breach or end the violation and may terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, or immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible. Notwithstanding the above, any breach related to the sale, transfer, or use or disclosure of Health Information for commercial advantage, personal gain, or malicious harm shall be considered non-curable. Business Associate's obligations under Article II shall survive the termination or expiration of this Agreement. Nevertheless, DHIN may continue to hold data in the terminated participant's data stage for historical and other purposes.

3.2.12 No Third Party Beneficiaries. There are no third party beneficiaries to the obligations of the participants of DHIN under this section.

3.2.13 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Health Information from Business Associate to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

3.2.14 Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of Health Information. The parties understand and agree that Covered Entity must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all Health Information that it receives or creates pursuant to this Agreement. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of any amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. Covered Entity may terminate this Agreement upon thirty (30) days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to this Section or (ii) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of Health Information that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and HIPAA Regulations.

#### **4.0 Other obligations of participation.**

4.1 Application for and participation in DHIN requires each participating entity and its agents and employees to the following provisions of this section as well as the obligations imposed elsewhere.

4.1.1 The participating entities, their agents and employees shall conduct their affairs with all other participants as well as the agents and employees of DHIN with the highest level of candor, complete honesty-in-fact, civility and professionalism.

4.1.2 The participants must respond to requests for information and complaints in a reasonable period. Participants must respond to requests for information and complaints that involve security and privacy within twenty-four hours unless the Director or his or her designee extends the time.

4.1.3 The participants must provide financial support by prompt payment in accordance with their prior agreement or as may be promulgated by rule by the Board in the future.

4.1.4 The participants must promptly report Security Incidents as defined in the prior section promptly to the Director and any other affected participant.

## **5.0 Dispute resolution and inquiries**

5.1 Any dispute that involves the DHIN or its interchange shall be subject to dispute resolution under this section. Such disputes may involve participants, the DHIN or members of the public where there is a claim that this or other regulations or statutes were violated by any of the forgoing. A dispute may also be an inquiry or request for information that is not responded to in a reasonable manner.

5.2 The Chair of the Board may appoint a number of individuals subject to approval by the Committee to serve on the Dispute Resolution Committee ["DRC"]. The DRC shall be comprised of panels of no less than three or more than five members. No member may serve on a case before the DRC where that member has a conflict of interest as set forth in 29 Del.C. Chapter 58. The presiding member of the panel must be a member of the Board. The Board may promulgate rules for procedures for matters to be determined by the DRC. The DRC and the Board are authorized to grant relief to include financial penalties, suspension and termination of an entity or individual's participation or use of the DHIN.

5.3 Any party aggrieved by the decision of the Panel may seek review by filing written exceptions to the Panel's decision within ten days of the decision as would be computed in the Delaware Superior Court. The review shall be presented to the Board who may overturn the Panel's decision by a majority vote of a quorum of the Board.

5.4 A aggrieved party may seek legal review on the record only in accordance with 29 Del.C. Ch. 101, Subchapter V.

## **6.0 Permitted uses by participants**

6.1 In an effort to maximize the health care benefits of the DHIN, participants are authorized to utilize the system to its maximum extent possible while maintaining the required high level of security and privacy for the information. Participants are authorized to use the DHIN without regard to whether the ordering entity is a participant of the DHIN. This includes participants that are subject to the Clinical Laboratory Improvement Act ["CLIA"] and regulations promulgated thereunder.

6.2 Participants shall comply with the data use agreements they entered into with the DHIN. The terms, conditions and requirements of the existing and future data use agreements may be determined and amended by the Board.

## **7.0 Patient access**

7.1 Individuals may be provided access to the information about them that is in the interchange in a manner and under terms and conditions that the Board shall set out by rule or procedure.

7.2 Individuals shall be informed of and may choose to preclude a search of their individual health information (as defined in above Section 3.1.1) in the DHIN Interchange after consultation with their health care provider and in accordance with the rules or procedures promulgated by Board.

## **8.0 Technical Standards**

8.1 The Board by rule or procedure shall establish the technical requirements for participation in the DHIN. These standards shall conform to or incorporate national standards to the extent such is feasible.

12 DE Reg. 979 (01/01/09)

# **103 Delaware Health Care Claims Database Data Collection Regulation**

## **1.0 Authority and Purpose**

1.1 Statutory Authority. 16 Del.C. §10306 authorizes DHIN to promulgate rules and regulations to carry out its objectives under 16 Del.C. Ch. 103, Subchapter II.

1.2 The Health Care Claims Database ("HCCD") was created by statute, pursuant to 16 Del.C. Ch. 103, Subchapter II, under the purview of DHIN, to achieve the "Triple Aim" of the State's ongoing health care innovation efforts: (1) improved health; (2) health care quality and experience; and (3) affordability for all Delawareans. The HCCD is created and maintained by the Delaware Health Information Network (DHIN), to facilitate data driven, evidence-based improvements in access, quality, and cost of healthcare and to promote and improve the public health through increased transparency of accurate Claims Data and information. To accomplish those objectives, a centralized Health Care Claims Database was established to enable the State to more effectively understand utilization across the continuum of health care in Delaware and achieve the Triple Aim.

## **2.0 Definitions**

The following words, terms, and phrases, when used in this regulation, shall have the following meaning, and use of the singular shall include the plural, unless the context clearly indicates otherwise:

"Claims Data" means as defined in 16 Del.C. §10312.

"Data Submission and Use Agreement" or "DSUA" shall mean the agreement between the HCCD Administrator and the Reporting Entity describing the specific terms and conditions for data submission and use. A template for the DSUA is Attachment B to this regulation.

"HCCD Administrator" shall mean the Delaware Health Information Network and its staff and contractor(s) that are responsible for collecting data submissions, providing secure production services and providing data access for approved users.

"Health Care Claims Database" or "HCCD" shall mean the database and associated technology components maintained by DHIN and authorized under 16 Del.C. Ch. 103, Subchapter II.

"Health Care Claims Database Committee" or the "Committee" shall mean the subcommittee established by the Delaware Health Information Network Board of Directors and governed by its by-laws that has the authority to determine when claims data should be provided to a Data Requester to facilitate the purposes of the enabling

legislation, and such other duties as designated the DHIN Board of Directors consistent with the enabling legislation.

"Health care services" means as defined in 16 Del.C. §10312.

"Health insurer" means as defined in 16 Del.C. §10312.

"Mandatory Reporting Entity" means as defined in 16 Del.C. §10312.

"Member" means individuals, employees, and dependents for which the Reporting Entity has an obligation to adjudicate, pay or disburse claims payments. The term includes covered lives. For employer-sponsored coverage, Members include certificate holders and their dependents. This definition includes all members of the State Group Health Insurance Program regardless of state of residence.

"Provider" means as defined in 16 Del.C. §10312.

"Pricing information" means as defined in 16 Del.C. §10312.

"Reporting Date" means as defined in 16 Del.C. §10312.

"Reporting Entity" means either a Mandatory Reporting Entity or a Voluntary Reporting Entity.

"Required Claims Data" as authorized under 16 Del.C. §10312(8) shall mean the required data containing records of member eligibility, medical services claims and pharmacy claims as specified in the Submission Guide.

"Submission Guide" shall mean the document providing the specific formats, timelines, data quality standards and other requirements for claims data submission, incorporated as Addendum One to the DSUA. It shall be established and maintained as technical guidance document and substantively updated on an annual basis.

"Third Party Administrator" means as defined in 18 Del.C. §102.

"Voluntary Reporting Entity" means as defined in 16 Del.C. §10312.

22 DE Reg. 465 (12/01/18)

### **3.0 Reporting Entity Requirements**

3.1 Registration: By December 31 of each year, each Mandatory Reporting Entity and each Voluntary Reporting Entity shall provide a contact and enrollment update form indicating if health care claims are being paid for Members and if applicable the types of coverage and estimated enrollment for the following calendar year. Each Mandatory Reporting Entity and participating Voluntary Reporting Entity is responsible for resubmitting or amending the form whenever modifications occur relative to the health care data files, type(s) of business conducted, or contact information.

3.2 Threshold for Covered Lives: Mandatory Reporting Entities with fewer than a total of 1000 covered lives may request an exemption from data submission at the end of a calendar year for the next year. If total enrollment subsequently increases to more than 1000 covered lives, the Mandatory Reporting Entity shall notify the HCCD Administrator to develop a compliance schedule. A Mandatory Reporting Entity that becomes eligible for an exemption shall continue to submit data for two full calendar quarters after receiving such exemption.

3.3 Excluded Mandatory Reporting Entities: As defined in 16 Del.C. §10312(3), the following providers of coverage are excluded from this rule: casualty insurance, long term care, dental care vision care, and employee welfare benefit plans regulated by ERISA.

3.4 Participating Voluntary Entities: Voluntary Reporting Entities are held to the same standards, expectations, and processes as Mandatory Reporting Entities for as long as they remain Reporting Entities.

3.5 New Reporting Entities that have not previously submitted files to the HCCD shall notify the HCCD Administrator and shall submit files according to the form and intervals described in Attachment A "Reporting Schedule."

3.6 Run-Out Period After Terminating Coverage: Mandatory Reporting Entities shall submit medical and pharmacy claims files for at least six months following the termination of coverage date for any Member for any reason, including a change in the status of the Reporting Entity. This should include any subrogated claims or claims held in suspense, with dates of service up to and including the termination date.

#### **4.0 Claims Data Submission**

4.1 Data Submission and Use Agreement: Reporting Entities shall enter into the HCCD Data Submission and Use Agreement, or "DSUA," no later than 90 days after the effective date of this rule. Such agreement shall be incorporated into this regulation as Attachment B.

4.2 Submission Guide: The HCCD Administrator shall develop and disseminate a Submission Guide, included as Addendum One to the DSUA. All files must conform to the formats and data quality requirements established in the Submission Guide, generally as follows:

- **Medical Claims File.** As detailed in the Submission Guide, Reporting Entities shall report information about all covered services provided to Members in all settings of care under all reimbursement arrangements, including but not limited to fee for service, capitated arrangements, and any other claims-based payment methods.
- **Pharmacy Claims File.** As detailed in the Submission Guide, Reporting Entities shall report pharmacy paid claims for covered pharmacy benefits that were dispensed to Members.
- **Member Eligibility File.** As detailed in the Submission Guide, Reporting Entities shall report information on every Member enrolled during the reporting month whether or not the Member utilized services during the reporting period.
- **Provider File.** As detailed in the Submission Guide, Reporting Entities shall report information that will uniquely identify health care Providers and allow retrieval of related information from eligibility, medical and pharmacy claims files. (1) Tax id numbers shall be submitted as part of the dataset except in the case that a provider uses their personal social security number as their tax id number in which case the tax id number need not be submitted.

4.3 Submission Schedule: Reporting Entities shall submit data files pursuant to the schedule in Attachment A.

4.4 Data Submitter Responsibilities: Each Reporting Entity is responsible for the submission of all Required Claims Data processed by any subcontractor on its behalf unless such subcontractor is already submitting the identical Required Claims Data as a Reporting Entity.

4.4.1 Upon notification by the HCCD Administrator, Reporting Entities shall provide corrected, conforming files within 10 business days. The HCCD Administrator may grant extensions of deadlines.

4.4.2 The HCCD Administrator may grant temporary or permanent approvals of a Reporting Entity's request for an override of a data submission requirement.

4.5 Replacement of Data Files. No Reporting Entity may replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period must be approved by the HCCD Administrator. Individual adjustment records may be submitted with any monthly data file submission.

4.6 Updating Submission Guide: The HCCD Administrator may update reporting specifications annually. Reporting Entities shall submit data that conforms to the updated specifications within 180 days after the effective date of the new version of the Submission Guide.

4.7 Submitting Additional Information: The HCCD Administrator may require Reporting Entities to submit information about the insurance product covering each member, including covered services, market sector, plan characteristics, total premiums, deductibles, co-insurance and copayments, by amending the Submission Guide.

## **5.0 Privacy, Confidentiality and Security**

5.1 Pursuant to 29 Del.C. §10002(I)(1) and (2), medical and other health care data on individual persons and trade secrets and commercial or financial information obtained from a person which is of a privileged or confidential nature is not a Public Record under the Freedom of Information Act.

5.2 All claims data shall be transmitted to the HCCD Administrator and stored in a secure manner compliant with the Security Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, as each is amended from time to time.

5.3 Transmission, storage and use or disclosure of claims data shall conform to all applicable Federal and State laws and regulations which address privacy, security, confidentiality, and breach notification of health care data.

## **6.0 Compliance**

Compliance: Mandatory Reporting Entities' failure to file, report or correct data or comply with data standards may be considered a violation of 16 Del.C. Ch. 103.

### **Attachment A Reporting Schedule**

#### **1. Test Files**

Reporting Entities shall submit one month of Required Claims Data files containing Member, Claims, Prescription Drugs and a sample of Provider data not more than 180 days after the effective date of this rule or as otherwise approved by the HCCD Administrator.

#### **2. Historical Files**

Reporting Entities shall submit Required Claims Data files for the previous four full calendar years that conform to required file formats on the 181st day after the effective date of this rule.

#### **3. Partial year submission for the current calendar year**

Reporting Entities shall submit Claims Data files for claims adjudicated in the elapsed months of the current calendar year, as directed by the HCCD Administrator.

**4. Ongoing Data Submission**

Reporting Entities shall submit monthly files containing claims paid and encounters adjudicated during the prior calendar month within 30 calendar days of the last day of the following month. The schedule for this submission is provided below and will continue in similar format in subsequent years. Submission dates falling on a weekend or legal holiday are extended to the next following business day.

<b>Submission Due to HCCD</b>	<b>Claims and Eligibility Begin Date</b>	<b>Claims and Eligibility End Date</b>
By March 1	January 1	January 31
By April 1	February 1	February 28/29
By May 1	March 1	March 31
By June 1	April 1	April 30
By July 1	May 1	May 31
By August 1	June 1	June 30
By September 1	July 1	July 31
By October 1	August 1	August 31
By November 1	September 1	September 30
By December 1	October 1	October 31
By January 1	November 1	November 30
By February 1	December 1	December 31

22 DE Reg. 465 (12/01/18)

**Attachment B  
Data Submission and Use Agreement Template**

**Data Submission and Use Agreement  
Between the Delaware Health Information Network  
and  
[name of Reporting Entity]  
For the Delaware Health Care Claims Database**

This Data Submission and Use Agreement between the Delaware Health Information Network ("DHIN"), a not-for-profit statutory instrumentality of the State of Delaware located at 107 Wolf Creek Blvd, Suite, 2, Dover, DE 19901 and [name of reporting entity] (the "Reporting Entity") sets forth the terms and conditions for the collection and use of health care claims data for the Delaware Health Care Claims Database.

**Recitals**

**WHEREAS** Under 16 Del.C. Ch. 103 as enacted, the Delaware General Assembly directed the Delaware Health Information Network to develop, maintain and administer the Delaware Health Care Claims Database (HCCD); and

**WHEREAS** Effective health care data analysis and reporting are essential to achieving the Triple Aim and helping move the state's health care system from a fee-for-service to a valued-based system that rewards providers for quality and efficiency of care; and

**WHEREAS** Claims data are an important component of population health research and analysis and support value-based health care purchasing and prevalence of illness or injury; and

**WHEREAS** provider and other health care entities accepting financial risk for managing the health care needs of a population should have access to claims data as necessary to effectively manage that risk; and

**WHEREAS** DHIN Is authorized to create the HCCD to facilitate data-driven, evidence-based improvements in health care and improve public health through increased transparency of accurate health care claims data and information; and

**WHEREAS** 16 Del.C. §10313 directs that DHIN and each reporting entity shall execute a data submission and use agreement that includes procedures for submission, collection, aggregation and distribution of claims data,

**NOW THEREFORE THE PARTIES AGREE AS FOLLOWS:**

1. Precedence

a. DHIN shall promulgate regulations to implement the provisions of 16 Del.C. Ch. 103, hereinafter, and as the same may be amended from time to time, the "HCCD Regulations". The HCCD Regulations shall take precedence over any terms and conditions represented in this Agreement.

b. Definitions in Section 2.0 of the HCCD Regulations shall also pertain to this Agreement.

2. Data Submission: Privacy and Security

a. 16 Del.C. Ch. 103 establishes DHIN as a public health authority that is responsible for public health matters pursuant to 45 CFR 164.501.

b. The HIPAA Privacy Rule permits covered entities to disclose PHI for general public health activities per 45 CFR 164.512(b)(1)(i).

c. Notwithstanding these provisions, DHIN shall ensure protection of patient privacy under provisions of 16 Del.C. Ch. 103, and including HIPAA, Title XIX and XXI of the Social Security Act and the HITECH Act and all other applicable state and federal privacy laws.

3. Data Submission: Collection

a. Reporting Entity shall submit Required Claims Data to the HCCD according to the specifications set forth in the Submission Guide. The Submission Guide is a technical guidance document, and may be updated and replaced without replacing the entire agreement.

b. Reporting Entity shall submit Required Claims Data to the HCCD according to the schedule set forth in Attachment A, Reporting Schedule, of the HCCD Regulations, or as mutually agreed. The schedule is included herein for convenience, but in case of conflict between this Agreement and the HCCD Regulations, the HCCD Regulations shall take precedence.

Submission Due to HCCD	Claims and Eligibility Begin Date	Claims and Eligibility End Date
By March 1	January 1	January 31
By April 1	February 1	February 28/29
By May 1	March 1	March 31
By June 1	April 1	April 30
By July 1	May 1	May 31
By August 1	June 1	June 30
By September 1	July 1	July 31
By October 1	August 1	August 31
By November 1	September 1	September 30
By December 1	October 1	October 31
By January 1	November 1	November 30
By February 1	December 1	December 31

c. Reporting Entity shall submit data files using protocols developed by the HCCD.

i. The Submission Guide shall reflect the content and formats in use by similar databases in other states.

ii. The data submission specifications shall be updated no more than once per calendar year.

iii. The parties agree to review and discuss any such changes prior to the effective date.

iv. Reporting Entity shall provide conforming data no later than 180 calendar days after publication of changes or by agreement between the HCCD Administrator and the Reporting Entity.

v. The HCCD Administrator may provide clarifications and technical corrections as needed to assist Reporting Entity in providing data submissions that conform to specifications.

d. Reporting Entity shall provide corrected data files within the timelines established in subsection 4.4.1 of the HCCD Regulations, or as mutually agreed.

e. Upon agreement between DHIN and the Reporting Entity, the Reporting Entity may submit additional data to the HCCD to improve or augment established reporting.

f. DHIN will review the Submission Guide and any subsequent annual revisions with Reporting Entity prior to the 180 day implementation period and on an annual basis thereafter.

g. Data collection methodologies in the Submission Guide shall facilitate uniformity among various health care claims databases of other states and specification of data fields, consistent with national standards.

h. Reporting Entity may request exemptions from specific data collection requirements, including minimum standards for reporting, subject to the approval of the HCCD Administrator.

4. Claims Data Uses

a. Pursuant to 16 Del.C. §10314(a)(1), Claims Data shall only be provided to a requesting party when a majority of the HCCD Committee determines that such request facilitates the statutory purposes of the HCCD.

i. Reporting Entities shall be given opportunity for comment prior to release of Claims Data.

ii. Determinations of the Committee shall be provided in writing to the requesting party.

iii. Decisions of the Committee shall be final and not subject to appeal.

b. Data Requestors may include payers, providers and purchasers.

c. The submitted claims data may be used for the broad purposes described in the enabling statute, including:

i. Alternative delivery and payment models

ii. Population health research

iii. Provider risk-sharing arrangements

iv. Public transparency

v. Other uses in furtherance of the "Triple Aim" of improved health, health care quality and experience, and affordability

d. Detailed permitted uses include, but are not limited to, the following:

i. Population health research and reporting on disease incidence, prevalence, and geographic distribution, costs of care and service utilization

ii. Health care service price variation reports and studies

iii. Design, model and evaluate payment models and purchasing initiatives

iv. Effects of care delivery strategies (e.g., care coordination, behavioral health integration) on utilization and outcomes

v. Efficiency of care, service models or procedures based on quality, value and/or outcomes

vi. Public facing provider performance reports

vii. Augment patient-specific records with data derived from the HCCD to improve the care of the patient, ensure better outcomes and deliver better value.

e. Publicly available data and reports shall, to the fullest extent practicable, comply with guidance in Statement 6 of the United States Department of Justice and Federal Trade Commission Enforcement Policy on Provider Participation in Exchanges of Price and Cost Information, August 1996, as the same may be amended, supplemented or modified from time to time, available at

[https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM\\_49](https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM_49) (last visited June 5, 2017).

f. Standard public-facing reports may be developed which provide aggregated, summary level views of the data in accordance with the statutory purpose of public transparency.

**Applicable Law:**

This Agreement shall be governed by and construed under the laws of the State of Delaware without regard to conflicts of law principles.

**IN WITNESS WHEREOF**, and intending to be legally bound thereby, the Parties have caused their duly authorized representatives to execute this Agreement.

**Signatories:**

[Reporting Entity] Delaware Health Information Network

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[Name] Janice L. Lee, MD

[Title] Chief Executive Officer

Date: Date:

21 DE Reg. 293 (10/01/17)

22 DE Reg. 465 (12/01/18)

**104 Delaware Health Care Claims Database Data Access Regulation**

**1.0 Authority and Purpose**

1.1 Statutory Authority. 16 Del.C. §10306 authorizes the Delaware Health Information Network (DHIN) to promulgate rules and regulations to carry out its objectives under 16 Del.C. Ch. 103, Subchapter II.

1.2 The Health Care Claims Database ("HCCD") was created by statute, pursuant to Chapter 103, Subchapter II of Title 16, under the purview of DHIN, to achieve the "Triple Aim" of the State's ongoing health care innovation efforts: (1) improved health; (2) health care quality and experience; and (3) affordability for all Delawareans. The HCCD is created and maintained by the DHIN, to facilitate data driven, evidence-based improvements in access, quality, and cost of healthcare and to promote and improve the public health through increased transparency of accurate Claims Data and information. To accomplish those objectives, a centralized Health Care Claims Database was established to enable the State to more effectively understand utilization across the continuum of health care in Delaware and achieve the Triple Aim.

**2.0 Definitions**

The following words and terms, when used in this regulation, have the same meaning as those in CDR 1-100-103 §2.0 unless the context clearly indicates otherwise:

"Approved User" means any person or organization that DHIN has authorized to view or access data from the Health Care Claims Database, including Delaware state agencies and DHIN itself.

"Claims Data" means Required Claims Data and any additional health care information that a voluntary reporting entity elects, through entry into an appropriate Data Submission and Use Agreement, to submit to the Delaware Health Care Claims Database.

"Clinical Proxy Data Elements" means any health care information contained within Claims Data which describes a rendered clinical service, including but not limited to: procedure codes, diagnosis codes, dates and locations of clinical services, healthcare providers, and pharmacy data, and excludes Pricing Information.

"Collaborating State Agencies" means the Delaware Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, and Division of Medicaid and Medical Assistance and their successors, if applicable.

"Community Health Record" or "CHR" means a searchable online portal that presents authorized users with a view of a patient's aggregated clinical data from all sources that contribute health data to DHIN. Access to patient records in the Community Health Record is on the basis of an established relationship between the patient and the end user for purposes of Treatment, Payment, and Operations, as those terms are defined in the HIPAA regulations, for Public Health purposes as defined in the HIPAA Privacy Rule, or by patient consent or patient request. Patients can opt out of allowing their CHR data to be searchable by anyone who was not the ordering Provider, but may not opt out of reporting required by law or regulation, such as, but not limited to, reporting of certain conditions to the Division of Public Health.

"Data Submission and Use Agreement" or "DSUA" means the agreement between the HCCD Administrator and the Reporting Entity describing the specific terms and conditions for data submission and use.

"De-Identified Data" means health information as defined in the HIPAA Privacy Rule, which is not considered PHI because it excludes the following direct and indirect patient identifiers:

- Direct Patient Identifiers
  - Names;
  - Telephone numbers;
  - Fax numbers;
  - Email addresses;
  - Social security numbers;
  - Medical record numbers;
  - Health plan beneficiary numbers;
  - Account numbers;
  - Certificate/license numbers;
  - Vehicle identifiers and serial numbers;
  - Device identifiers and serial numbers;
  - URL's;
  - IP addresses;
  - Biometric identifiers, including fingerprints;
  - Full-face photographs;
  - Any other unique identifying characteristic or code.
  
- Indirect Patient Identifiers
  - All geographic subdivisions smaller than a state, except for the initial three digits of a zip code;

- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older

"HCCD Administrator" means the Delaware Health Information Network and its staff and contractor(s) that are responsible for collecting data submissions, providing secure production services and providing data access for approved users.

"Health Care Claims Database" or "HCCD" means the database and associated technology components maintained by DHIN and authorized under 16 Del.C. Ch. 103, Subchapter II.

"Health Care Claims Database Committee" (the "Committee") means the subcommittee established by the Delaware Health Information Network Board of Directors and governed by its by-laws that has the authority to determine when applications for Claims Data should be provided to a data requestor to facilitate the purposes of the enabling legislation, and such other duties as designated by the DHIN Board of Directors consistent with the enabling legislation.

"Health care services" means as defined in 18 Del.C. §6403.

"Health Insurer" means as defined in 16 Del.C. §10312.

"Identified Data" means data that contains direct patient identifiers.

"Limited Data Set" means PHI that excludes 16 categories of direct identifiers and may be used or disclosed, for purposes of research, public health, or health care operations, without obtaining either an individual's Authorization or a waiver or an alteration of Authorization for its use and disclosure, with a data use agreement. The following data elements are removed from a Limited Data Set:

- Names;
- Postal address information, other than town or city, state, and ZIP Code;
- Telephone number;
- Fax numbers;
- Electronic mail addresses;
- Social Security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web universal resource locators (URLs);
- Internet protocol (IP) address numbers;
- Biometric identifiers, including fingerprints and voiceprints;
- Full-face photographic images and any comparable images.

A Limited Data Set may include:

- City, state, ZIP Code;
- Elements of dates;
- Other numbers, characteristics, or codes not listed as direct identifiers.

"Mandatory Reporting Entity" means the following entities, except as prohibited under federal law:

- The State Employee Benefits Committee and the Office of Management and Budget, under each entity's respective statutory authority to administer the State Group Health Insurance Program in 19 Del.C. Ch. 96, and any Health Insurer, Third Party Administrator, or other entity that receives or collects charges, contributions, or premiums for, or adjusts or settles health claims for, any State employee, or their spouses or dependents, participating in the State Group Health Insurance Program, except for any carrier, as defined in 29 Del.C. §5290, selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under 29 Del.C. Ch. 52C.
- The Division of Medicaid and Medical Assistance, with respect to services provided under programs administered under Titles XIX and XXI of the Social Security Act.
- Any Health Insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year.
- Any federal health insurance plan providing Health Care Services to a resident of this State, including Medicare fee for service, Medicare Part C/Medicare Advantage and Medicare Part D Prescription Drug plans and the Federal Employees Health Benefits Plan.

"Member" means individuals, employees, and dependents for which the Reporting Entity has an obligation to adjudicate, pay or disburse claims payments. The term includes covered lives. For employer-sponsored coverage, Members include certificate holders and their dependents. This definition includes all members of the State Group Health Insurance Program regardless of state of residence.

"Pricing Information" means any information referring to prices charged or paid, and includes the pre-adjudicated price charged by a Provider to a Reporting Entity for Health Care Services, the amount paid by a Member or insured party, including co-pays and deductibles, and the post-adjudicated price paid by a Reporting Entity to a Provider for Health Care Services.

"Protected Health Information" or "PHI" means individually identifiable health information as defined in the HIPAA Privacy Rule.

"Provider" means a hospital, facility, or any health care practitioner licensed, certified, or authorized under State law to provide Health Care Services and includes hospitals and health care practitioners participating in group arrangements, including accountable care organizations, in which the hospital or health care practitioners agree to assume responsibility for the quality and cost of health care for a designated group of beneficiaries.

"Re-disclosure" means the publication, distribution or other dissemination of Claims Data released to an Approved User using any medium and in any format, context or structure.

"Reporting Entity" means either a Mandatory Reporting Entity or a Voluntary Reporting Entity.

"Required Claims Data" as authorized under 16 Del.C. §10312(8) means the required data containing records of member eligibility, medical services claims and pharmacy claims as specified in the Submission Guide.

"Submission Guide" means the document providing the specific formats, timelines, data quality standards and other requirements for claims data submission, incorporated as Addendum One to the DSUA. It shall be established and maintained as technical guidance document and substantively updated on an annual basis.

"Voluntary Reporting Entity" means any of the following entities that has chosen to submit or has been instructed to submit data at the request of an employer or client and enters into a Data Submission and Use Agreement, unless such entity is a Mandatory Reporting Entity:

- Any Health Insurer.
- Any Third Party Administrator not otherwise required to report.
- Any entity, which is not a Health Insurer or Third Party Administrator, when such entity receives or collects charges, contributions, or premiums for, or adjusts or settles health care claims for, residents of this State.

### 3.0 General Data Access Provisions

3.1 HCCD data may be released to a person or organization for purposes of:

3.1.1 Promoting and improving public health;

3.1.2 Advancing the "Triple Aim" of improving health, improving health care quality and experience, and improving affordability;

3.1.3 Providing information to effectively manage risk for the health needs of a population.

3.2 The DHIN may provide HCCD data or data access at the following levels of detail, per the procedures established in this Regulation:

3.2.1 De-Identified Data

3.2.2 Limited Data Sets

3.2.3 Identified Data

3.3 Except as otherwise specified in this Regulation, all requests for HCCD data or data access shall require completion of a written Data Access Application that describes the intended purpose and use of the data, the justification for the data request, and the security and privacy measures that will be used to safeguard the data and prevent unauthorized access to or use of the data as well as such other acknowledgments as may be included on the Data Request Application. Exceptions to this rule include:

3.3.1 DHIN may incorporate HCCD Clinical Proxy Data Elements into the Community Health Record for purposes of treatment and care coordination, without a written application or Committee review.

3.3.2 DHIN may make HCCD Clinical Proxy Data Elements available to the Members to whom they apply without a written application or Committee review. Members may access their health data by enrolling in DHIN's Personal Health Record on the DHIN website at [www.DHIN.org](http://www.DHIN.org).

3.3.3 Requests from Reporting Entities for their own data will not require Committee review.

3.3.4 Collaborating State Agencies may access HCCD data without Committee review by entering into an interagency agreement with the DHIN. The allowable uses of Claims Data by Collaborating State Agencies will be posted on DHIN's web site for public transparency. The interagency agreement shall include but not be limited to the following:

3.3.4.1 Confirmation that the Collaborating State Agency will conform to DHIN's confidentiality and data security protocols and all applicable state and federal laws relating to the privacy and security of PHI;

3.3.4.2 Confirmation that the Collaborating State Agency will abide by re-disclosure requirements as specified in Section 6 of this Regulation.

3.3.5 Requests from Providers for their own data, as submitted by Reporting Entities, will not require Committee review.

3.4 Applications for De-Identified Data may be eligible for expedited review.

3.5 The Committee shall review, without exception, the following types of applications to confirm the intended use is consistent with the statutory purpose of the HCCD:

3.5.1 Applications for Limited Data Sets;

3.5.2 Applications for Identified Data;

3.5.3 Applications from out-of-state commercial requestors who are not Reporting Entities and whose intended use will not directly benefit Delawareans;

3.5.4 Applications for Pricing Information and other sensitive financial data elements.

3.6 DHIN will post an annual summary of disclosures on its website.

#### **4.0 Structure and Duties of the Committee**

4.1 The Committee shall have a chairperson and members appointed by the DHIN Board of Directors.

4.2 The Committee shall be comprised of five (5) to eleven (11) members and shall be representative of various stakeholder groups, including, where possible, consumers, employers, health plans, hospitals, physicians, researchers, and State government.

4.3 The Committee shall finalize a data request application, establish business operating rules for the review and consideration of applications, and determine a schedule for reviewing applications. These business rules shall be subject to periodic updates by the Committee and shall be maintained on the DHIN website.

4.4 The Committee shall consider any comments received from Reporting Entities whose Claims Data is being requested. The Committee shall approve an application by majority vote after finding the following:

4.4.1 The intended use is consistent with the statutory purpose of the HCCD;

4.4.2 Access to the requested data is necessary to achieve the intended goals, including but not limited to the need for identifiable data, if requested;

4.4.3 The request complies with all applicable state and federal laws relating to the privacy and security of PHI;

4.4.4 The request complies, to the fullest extent practicable, with guidance found in Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information;

4.4.5 The applicant is qualified to serve as a responsible steward of the requested data.

4.5 The Committee reserves the right to ask an applicant to acquire Institutional Review Board review, or its equivalent, prior to approving an application.

4.6 After a decision is reached by the Committee, public notice will be posted on the DHIN website that an application for data access was received, by whom it was submitted and for what purposes, and the decision of the Committee to grant or deny the application. The final determination of the Committee shall not be subject to appeal.

## **5.0 Applications for HCCD Data**

5.1 The DHIN shall notify a Reporting Entity when an application is received for Claims Data which was submitted to the HCCD by that Reporting Entity. The notification shall include but not be limited to: a summary of the request; the specific Claims Data element(s) being requested; and the name of the requestor. Reporting Entities will have ten business days to provide written comment to DHIN regarding the request.

5.2 Upon the Committee's approval of an application for HCCD data, the applicant shall sign a legally binding data use agreement. The data use agreement will include but not be limited to:

- 5.2.1 Confirmation of compliance with the DHIN's confidentiality and data security protocols;
- 5.2.2 Confirmation of compliance with the HCCD re-disclosure requirements;
- 5.2.3 Commitment to use HCCD data for the sole purpose of executing the approved research project;
- 5.2.4 Commitment to document data destruction processes at the end of the project.
- 5.2.5 Confirmation of compliance with all statutory and regulatory requirements.

## **6.0 Re-Disclosure Requirements**

6.1 The DHIN and Collaborating State Agencies may issue public reports with aggregated HCCD data that adhere to the re-disclosure requirements without Committee review and approval.

6.2 Any re-disclosure of HCCD data made by anyone other than DHIN or a Collaborating State Agency, shall require Committee review and approval. All HCCD data shared publicly or re-disclosed to anyone other than an Approved User shall adhere to the following re-disclosure requirements:

- 6.2.1 Adhere to CMS cell size suppression requirements for CMS Research Identifiable Files;
- 6.2.2 Exclude any Reporting Entity-specific Pricing Information that includes post-adjudicated claims data.
- 6.2.3 Follow guidance found in Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information.

## **7.0 Fees**

7.1 DHIN may charge a reasonable cost-based fee for preparing and transmitting HCCD data. This fee may include: costs of aggregating, storing, extracting, de-identifying, and transmitting the information; associated infrastructure and staff labor costs; costs for programming and data generation; allocated indirect operating costs, other costs associated with the production and transmission of data sets, and such other costs or fees as DHIN determines necessary.

7.2 HCCD data and data access will always be provided free of charge to the following entities:

- 7.2.1 The Office of Management and Budget;
- 7.2.2 State Employee Benefits Committee;
- 7.2.3 Division of Public Health;
- 7.2.4 Division of Medicaid and Medical Assistance.

7.3 At DHIN's discretion, fees may be reduced or waived for certain entities, including but not limited to:

- 7.3.1 CMS;
- 7.3.2 Reporting Entities;
- 7.3.3 Entities that submit other data to the DHIN.

7.4 The DHIN shall have a record of payment in full prior to providing data or access to Approved Users.

7.5 Fees shall be deposited into a DHIN account to support costs of operating the HCCD.

## **8.0 Penalties**

8.1 If an Approved User violates the terms of the data use agreement, the DHIN may take one or more of the following actions:

- 8.1.1 Revoke permission to use the data;
- 8.1.2 Pursue civil or administrative enforcement action under applicable Delaware state law.
- 8.1.3 Notify the requester's licensing body, if any, and if none, its accreditation body.

8.2 If the violation pertains to access or misuse of the data, the DHIN shall report the violation to the office of the Attorney General, pursuant to 16 Del.C. §10307(c).

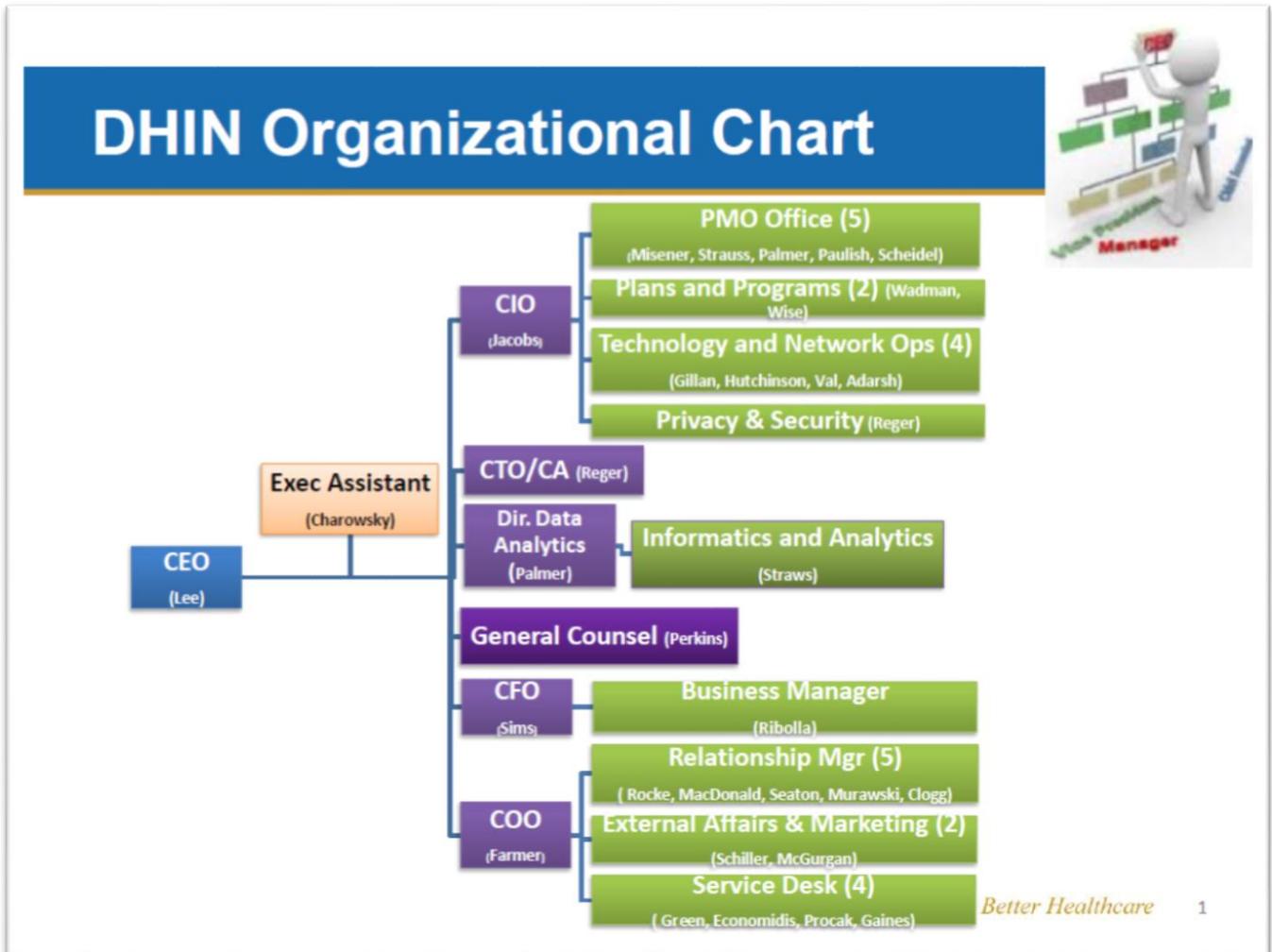
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**APPENDIX C****Board Members**

	<b>NAME</b>	<b>TERM</b>	<b>MEMBERSHIP CATEGORY</b>
1.	Randall Gaboriault - Chair Chief Information Officer Christiana Care Health System	01-2011 to 10-2019 8 years	DHIN Board of Directors, Executive Committee Member
2.	Stephen Lawless, MD –Vice Chair Vice President, Quality and Patient Safety, Nemours/Al DuPont Hospital for Children	06-2012 to 10-2019 7 years	DHIN Board of Directors, Executive Committee Member
3.	Dr. Jonathan Kaufmann, D.O. - Secretary Chief Medical Officer, Bayhealth Medical Center	04-2018 to 06-2021 3 years	DHIN Board of Directors, Executive Committee Member
4.	Meredith Stewart-Tweedie - Treasurer Vice President, Government Affairs and Strategic Engagement, Christiana Care Health System	10-2015 to 10-2019 4 years	DHIN Board of Directors, Executive Committee Member
5.	James L. Collins Chief Information Officer Department of Technology & Information, State of Delaware	2-2017 to 10-2020 3 years	DHIN Board of Directors, Executive Committee Member
6.	Steve Constantino Director, Health Care Reform and Financing, Delaware Department of Health and Social Services	07-2018 to 10-2021 3 years	DHIN Board of Directors
7.	Jeffrey E. Hawtof, MD, FAAFP Vice President, Medical Operations & Informatics Beebe Healthcare	01-2013 to 10-2019 6 years	DHIN Board of Directors
8.	A. Richard Heffron President (Ret.) Delaware State Chamber of Commerce	01-2011 to 10-2019 8 years	DHIN Board of Directors, Executive Committee Member
9	Dr. Randeep Kahlon First State Orthopedics, Director of Orthopedic Education, Christiana Care Health System	09-2017 to 10-2020 3 years	DHIN Board of Directors
10.	William E. Kirk, III, Esq. Executive Vice President (Ret.) Highmark Blue Cross Blue Shield of Delaware	01-2011 to 10-2020 9 years	DHIN Board of Directors, Executive Committee Member
11.	Kathleen S. Matt, PhD Dean, College of Health Services University of Delaware	05-2013 to 10-2020 7 years	DHIN Board of Directors
12.	Troy McDaniel Chief Administrator Division of Medicaid & Medical Assistance (Delaware)	09-2017 to 10-2020 3 years	DHIN Board of Directors
13.	Nathan Merriman, MD, MSCE Gastroenterology Associates of Delaware, Director of Endoscopy, Christiana Care Health System	10-2015 to 10-2019 4 years	DHIN Board of Directors
14.	Faith Rentz Director, Statewide Benefits Office, State of Delaware	10-2018 to 10-2021 3 years	DHIN Board of Directors
15.	Remy Richman Vice President, Market Executive Director AETNA	08-2017 to 10/2020 3 years	DHIN Board of Directors
16.	Stephen Saville, JD EVP Corporate Development OGH, LLC   Workforce Solutions	05-2013 to 10-2019 6 years	DHIN Board of Directors

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**APPENDIX D**



**DHIN Staff and Responsibilities** *revised 3.19*

\* denotes a member of the DHIN management team

**\*Dr. Jan Lee: Chief Executive Officer**

- Provides strategic leadership and day-to-day management of the organization's programs, operations and policy development (40%)
- Collaborates with key leaders in the State and the statewide healthcare community to further DHIN's mission and value to stakeholders (35%)
- Serves as DHIN's representative to task forces, committees and commissions – i.e. Delaware Health Care Commission, Delaware Center for Health Innovation, Christiana Care Board of Trustees, etc. (15%)
- Oversees DHIN's \$8.5M budget (10%)

**Ali Charowsky: Executive Assistant**

- Provides administrative support to the CEO (50%)
- Provides administrative support to the management and staff of DHIN (25%)
- Coordinates requests from DHIN Board members and business partners, as well as dignitaries and staff from state and federal governments and government agencies (25%)

**\*Mark Jacobs: Chief Information Officer**

- Develops strategy for DHIN’s data management, system architecture, service levels, disaster recovery, risk management and mitigations, as well as implementation of features, functions, data types and sources of health information (35%)
- Responsible for vendor management, ensuring that contract deliverables are met on time and within scope and budget (35%)
- Oversees DHIN’s internal information technology and communications systems and projects (30%)

**\*Lynn Misener: Senior Project Manager**

- Oversees IT integration of projects of a four-six month duration (40%)
- Manages cooperative, voluntary relationships among the project participants, both internal and external, while maintaining responsibility for all project documentation (30%)
- Responsible for IT vendor and stakeholder management (30%)

**Catherine Paulish, Brandy Strauss, Elise Scheidel: Project Managers**

- Develop/update project plans for IT projects, to include project objectives, scope, technologies, systems, specifications, schedules, funding, staffing and deliverables (35%)
- Develop and manage work breakdown structure of IT projects to estimate effort required for each task (35%)
- Complete all required documentation included in the Project Management Methodology to maintain accurate records of project and portfolio activities (30%)

**\*Randy Farmer: Chief Operating Officer**

- Drives the overarching commercial strategy, specifically in the areas of marketing, brand development, product development, operational integrity, business development and customer service (45%)
- Sources and pitches new business opportunities for DHIN (35%)
- Oversees business relations, service desk and marketing staff (20%)

**\*Stacey Schiller: Director, External Affairs**

- Manages marketing, public and media relations and brand development (45%)
- Oversees advocacy, outreach and government relations efforts (45%)
- Provides support to COO and executive team with regards to sales and service materials (10%)

**\*Jamie Roche: Director, Business Relations**

- Develops strategies for and oversees ongoing provider relations, recruitment and training initiatives (55%)
- Sources and pitches new business opportunities for DHIN (30%)
- Manages team of business relationship managers (15%)

**Mike MacDonald: Senior Business Relationship Manager**

- Serves as day-to-day contact for assigned practices, managing recruitment, training, customer service and technical assistance (75%)
- Develops training videos and support for new and existing services (25%)

**Brooke Clogg, Ed Seaton and Garrett Murawski: Business Relationship Managers**

- Serve as day-to-day contacts for assigned practices, managing recruitment, training, customer service and technical assistance (100%)

**Ashley Green: Supervisor, Service Desk**

- Provides direct support to stakeholders experiencing technical-related issues with DHIN services (40%)
- Manages and trains service desk staff (40%)
- Updates and maintains system settings and serves as escalation point for requests (20%)

**Brent Gaines, Mike Procak, Nikos Economidis: Technical Support Specialists**

- Serve as initial point of contact for customers (60%)
- Update and maintain system settings (15%)
- Monitor systems and alerts in technical environment proactively for any changes or errors (25%)

**Dave McGurgan: Consumer Application & Marketing Coordinator**

- Manages DHIN presence on all social media channels (35%)
- Develops digital content to support/promote DHIN services and initiatives (35%)
- Provides website and web content management (30%)

**\*Mike Sims: Chief Financial Officer**

- Oversees all accounting and finance activities for DHIN, including payroll, vendor and contractor payments; supporting annual external audits and preparation and presentation of financial statements (35%)
- Develops financial/business models and prepares pricing and payment terms for new services that DHIN pursues (35%)
- Manages compliance with the requirements for draw-down of grant funds and all financial reporting required by the grantor, as well as grant close-out activities (30%)

**Michele Ribolla: Business Manager**

- Manages biweekly and monthly reporting, bookkeeping, accounts payable, accounts receivable and other finance-related projects to include fiscal year budgets (25%)
- Maintains annual budget for DHIN projects, monitors milestone payments to vendors and manages customer invoicing (25%)
- Performs weekly/bi-weekly audits on Community Health Record users and contacts the practices when necessary should an infraction occur (25%)
- Serves as liaison with employee benefits providers and timekeeping service and maintains Policies & Procedures Manual (25%)

**\*Richard Wadman: Senior Program Manager**

- Develops business requirements, articulates corresponding technical requirements and generates use cases and project statements for each customer and service provided by DHIN (100%)

**Randy Wise: Junior Project Manager**

- Develops business requirements, articulates corresponding technical requirements and generates use cases and project statements for each customer and service provided by DHIN (85%)
- Assists with defining requirements and writing Requests for Proposals for DHIN procurements (15%)

**\*Jeff Reger: Chief Technology Officer and Privacy and Security Officer**

- Oversees infrastructure supporting DHIN’s internal business operations, as well as the network and infrastructure supporting DHIN’s customer-facing service lines (25%)
- Monitors the security of the information processed and stored by DHIN (20%)
- Plans, designs and implements IT architecture that is congruent with DHIN’s infrastructure and technology roadmap (20%)
- Responsible for backup, disaster recovery and business continuity planning and regular testing (15%)
- Oversees compliance with HITRUST program to ensure that DHIN is compliant with all pertinent legal, regulatory and contractual privacy and security requirements (10%)
- Trains and supervises DHINs Network Operations staff (10%)

**Andy Gillan, Erica Hutchinson, Sam Adarsh, Jon Val: Network & Operations Analysts**

- Monitor DHIN’s IT operations and network infrastructures (35%)
- Implement new projects and connections with new data senders (35%)
- Provide application, business office system support and production support (30%)

**\*Terri Lynn Palmer: Director of Data Analytics**

- Oversees DHIN’s analytics services for clinical data, specifically the Health Care Claims Database (70%)
- Oversees DHIN’s HITRUST program to ensure that DHIN is compliant with all pertinent legal, regulatory and contractual privacy and security requirements (30%)

**Pier Straws: Health Informatics Data Analyst**

- Identifies trends and patterns using sampling methods and statistical modeling techniques (35%)
- Develops meaningful reports from databases/data repositories (35%)
- Performs analysis that helps improve process efficiency and data quality (30%)

**\*Scott Perkins: General Counsel**

- Reviews vendor contracts and consults on matters of privacy and security (50%)
- Provides legal counsel relating to establishing and maintaining the Health Care Claims Database (25%)
- Monitors legal and privacy compliance with DHIN’s HITRUST program certification (25%)

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## **APPENDIX E**

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### **BY-LAWS**

#### **OF**

#### **Delaware Health Information Network**

#### **ARTICLE I - NAME**

The name of the entity is: Delaware Health Information Network (DHIN)

#### **ARTICLE II - OFFICES**

The Board of Directors of the DHIN (the "Board") shall establish the location of the principal executive office of the DHIN at any appropriate location within the State of Delaware, or at such other place as shall be lawfully designated by the Board of Directors as the affairs of the DHIN may require from time to time.

#### **ARTICLE III - CORPORATE PURPOSES**

The purposes of the DHIN shall be to facilitate the exchange of electronic health information among health care providers in Delaware; to improve the care received by consumers served by Delaware's health care system; to reduce medical errors associated with incomplete information available to providers of medical care; to improve communication among healthcare providers and their patients; to reduce the number of duplicative tests; and to afford specialists a better understanding of the patient upon referral from his/her primary care physician. The purposes of the DHIN shall also include the administration, operation and maintenance of a Delaware Health Care Claims Database as set forth in 16 *Del. C* Ch. 103, *Subch.* II. The DHIN shall operate exclusively for charitable, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, or corresponding section of any future federal tax code; and generally to engage in any other lawful endeavor or activity in furtherance of any of the foregoing purposes.

#### **ARTICLE IV - BOARD OF DIRECTORS**

1. General. The management and affairs of the DHIN shall be at all times under the direction of a Board of Directors to be elected from time to time as stated herein. Each Director shall be of legal age, and need not be a resident of the State of Delaware.

2. Number. The number of voting members of the Board shall be consistent with the requirements set forth in 16 *Del. C. § 10302*.

3. Qualifications: Consistent with the requirements of 16 *Del. C. § 10302*, Directors appointed to the Board ideally shall have experience in one of the following areas: clinical care, finance, health care/privacy law, information technology, and management/administration. The DHIN Board Development Committee shall seek to establish a balance of these skill sets among appointed Directors. The Chief Executive Officer of DHIN shall develop a comprehensive training/orientation curriculum for new Directors.

4. Directors. The Directors of the DHIN shall be comprised of the following nineteen (19) members as specified in §10302(a), Title 16 of the Delaware Code:

1. The Director of the Office of Management and Budget or his/her designee;
2. The Chief Information Officer of the Department of Technology and Information or his/her designee;
3. The Secretary of the Department of Health and Social Services or his/her designee;
4. The Controller General or his or her designee;
5. Six (6) members, appointed by the Governor, including at least one person who shall represent the interests of medical consumers and at least three with experience and/or expertise in the healthcare industry;
6. Three (3) members appointed by the Governor representing hospitals or health systems;
7. Three (3) members appointed by the Governor representing physicians;
8. One (1) member appointed by the Governor representing businesses or employers; and
9. Two (2) members appointed by the Governor representing health insurers or health plans.

The Chief Executive Officer of the Delaware Health Information Network shall serve on the Board of Directors in a non-voting capacity.

5. Vacancies. Vacancies occurring in the Board by death, resignation, refusal to serve, or otherwise, shall be filled for the unexpired term by a Director appointed by the Governor.

6. Resignation. Any Director may resign at any time by giving written notice to the Chair and the Secretary of the Board of Directors. Such resignation shall take effect at the time specified or, if no time is specified, at the time of its acceptance as determined by the Chair or the Board.

7. Attendance Expectations. Directors are expected to attend all meetings of the Board whether regular or specially called meetings, either in person or by the electronically provided means set forth herein. As set forth in 16 Del. C. § 10302(a), a Director who is absent without adequate reason for three (3) consecutive meetings, or who fails to attend at least half of all regular business meetings during any calendar year, may be removed from the Board with the approval of the Governor upon a recommendation by the Board.

8. Restrictions. The Board may recommend to the Governor that, consistent with the requirements set forth in 16 Del. C. § 10302(a) and to the extent practicable, no more than one Director may serve from any one organization or agency from which that Director receives income or primary employment.

9. Terms. A Director may serve two (2) consecutive, three (3) year terms. Directors whose terms have ended or who have resigned from a term will not be eligible for re- appointment to the Board for a period of one (1) year

10. Right of Inspection. Each Director has the right, at any reasonable time, to inspect and copy any of the DHIN's books, records, and documents of every kind and to inspect the DHIN's physical properties.

11. Conflict of Interest. As a public instrumentality of the State of Delaware, DHIN and certain of its officers and employees are subject to the Laws Regulating the Conduct of Officers and Employees of the State, as set forth in Chapter 58, Title 29 of the Delaware Code. All Directors, Officers, and committee members shall be required, upon their appointment and on an annual basis thereafter, to sign a conflict of interest statement on a form to be approved by the Executive Committee.

#### ARTICLE V - MEETINGS OF THE BOARD

1. Place of Meeting. The meetings of the Board shall be held at the principal office of the DHIN or at any place within the State of Delaware that the Board may from time to time designate.

2. Annual Meeting. An annual meeting of the Board shall be held within four months of the

close of the fiscal year each year, or at such other time as designated by the Chair, provided that if the annual meeting is to be held at such other time, the notice of the meeting shall give the date, time and place and designate it as the annual meeting. The annual meeting shall be open to any citizen of the State of Delaware who has indicated an interest in the purpose and mission of the DHIN.

3. Regular and Special Meetings. Regular meetings of the Board shall be held at such frequency, time and place as may be specified by the resolution of the Board. Special meetings of the Board of Directors shall be held whenever called by the Chair, or by a majority of the Directors then in office. Special meetings of the Board of Directors shall be held at such place either within or without the State of Delaware, as shall be stated in the call of the meeting.

4. Board Meeting Attendance by Telephone, Webinar or Other Means: The Board shall conduct its business through in-person meetings, except that Directors may from time to time attend by telephone, or meetings may be convened by video-conference or other alternative means, as may be required under special circumstances as determined by the Chair and the Executive Director. Meetings conducted by videoconference, webinar or similar means, or board member participation in an in-person meeting by phone, shall be subject to the requirements of the Delaware Freedom of Information Act, 29 *Del. Ch.* 101.

5. Notice of Meetings. The Secretary or his/her authorized designee shall give notice to each Director of each annual, regular or special meeting by mailing the same at least seven (7) days before the meeting to his/her address as shown by the records of the DHIN or by e-mailing or faxing the same not less than seven (7) days before the meeting, which notice shall state the time and place of the meeting, including agenda items, and notification of actions expected to be taken. A Director may waive notice before, at or after any meeting by writing or by electronic means. Attendance by a Director at a meeting shall not constitute waiver of notice of such meeting if a Director attends for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

6. Quorum. As set forth in 16 *Del. C. §* 10302, the Board is authorized to conduct its business by a majority of a quorum. A quorum is a simple majority of the members appointed. Once a quorum is present to organize the meeting it shall continue in effect notwithstanding the subsequent withdrawal of any of those present unless the status of a quorum is questioned by a Director.

7. Organization. At all meetings of the Board of Directors, the Chair shall preside. The Secretary or the Secretary's designee shall keep a record of the proceedings of the meetings. The Chair and Secretary shall do and perform such other duties as may from time to time be assigned to each of

them, respectively by the Board of Directors. At such time that the Chair is unable to preside over the meeting, the Vice Chair shall preside.

8. Order of Business. The order of business at all meetings of the Board of Directors, unless otherwise determined by the affirmative vote of a majority of the Directors present shall be determined by the presiding officer.

#### ARTICLE VI - COMPENSATION OF DIRECTORS

Directors acting as such shall not receive any compensation for their services as Directors, but the Board may, by resolution, authorize reimbursement of reasonable expenses incurred in the performance of their duties. Such authorization may prescribe the procedure for approval and payment of such expenses by designated officers of the DHIN. Nothing herein shall preclude Directors from serving the DHIN in any other capacity and receiving compensation for such services; provided, however, that any such compensation shall be subject to all applicable requirements concerning conflict of interest and disclosure.

#### ARTICLE VII – OFFICERS

1. Election - Title - Term. The officers of the DHIN shall be a Chair, Vice Chair, Secretary and a Treasurer, and such other officers and assistant officers as may be appointed pursuant to these by-laws. Each officer shall be elected annually by the Board of Directors at its annual meeting from the Board of Directors, to serve until the next ensuing annual meeting, or until a successor shall have been duly elected and shall have qualified. At least thirty (30) days before the annual meeting, the Board Development Committee shall submit to the Board Chair proposed nominations for individuals to serve as officers. Each Director shall be given a list of the nominees at least seven (7) days prior to the annual meeting. Each Director shall be entitled to one (1) vote for each officer position to be filled and the result will be determined by a vote equaling the number of the majority of the Directors present.

Any two or more offices may be held by the same person, except the same person may not hold the office of Chair and as Vice Chair, Secretary, or Treasurer simultaneously. All officers of the DHIN shall do and perform such other duties as may from time to time be assigned to each of them, respectively by the Board of Directors.

The Chief Executive Officer of the DHIN shall be a non-voting member of the Board, Executive Committee and any other committee of the DHIN. The Chief Executive Officer shall have the authority to hire, fire and discipline employees and other personnel, oversee the allocation of financial resources within budget or under the constraints as set by the Board. The Chief Executive Officer may execute

contracts and agreements up to a dollar limit approved by the Board. The Chief Executive Officer shall do and perform such other duties as may from time to time be assigned by the Board of Directors.

2. Tenure of Officers. All officers, employees and agents shall be subject to removal at any time by the affirmative vote of a majority of the members of the Board then present.

3. Chair. One Director shall be elected to perform the role of Chair of the Board by a majority of Directors then present. The Chair shall: preside over meetings of the Board; maintain good order; determine the agenda for meetings; appoint the membership of committees and work groups, except the Executive Committee; execute documents in the name of the Board; and perform such other matters as determined by the Board.

4. Vice Chair. One Director shall be elected to serve as Vice-Chair by a majority of the Directors then in service. The Vice Chair shall perform the duties and exercise the powers of the Chair when the Chair is absent or unable to act, subject to the control of and to the extent authorized by the Board of Directors. The Vice Chair will serve until the next ensuing annual meeting (or at such time the Chair vacates his/her position), upon which time the Vice Chair shall assume the role of Chair of the Board unless otherwise determined by the affirmative vote of a majority of the members of the Board then present.

5. Treasurer. One Director shall be elected to serve as the Treasurer by the majority of Directors then present. The Treasurer shall oversee fiscal matters of the DHIN; provide an annual budget to the Board for approval; and ensure the development and board review of financial policies and procedures, except as otherwise provided by the Board. The Treasurer shall serve as Chair of the Finance Committee. If required by the Board, he/she shall give bond for the faithful discharge of his/her duties in such sum and with such surety or sureties as the Board may require. The Board shall have authority to appoint an Assistant Treasurer if deemed necessary in the Board's discretion.

6. Secretary. One Director shall be elected to serve as Secretary by a majority of Directors then in service. The Secretary shall maintain the records of the Board and its members, and attest to the official matters of the Board, except as otherwise provided by the Board. The Secretary will serve as Chair of the Board Development Committee.

#### ARTICLE VIII – COMMITTEES OF THE BOARD

1. Committee Composition. Members of DHIN committees shall be nominated by the Chair and approved by the Board of Directors. All committees of the DHIN Board shall be chaired by a Director. Non-Directors with an interest in the purpose and mission of the DHIN may serve by invitation

and Board approval on any DHIN committee except the Executive Committee, however, the majority of each committee must be DHIN Directors. All committee members, both Directors and non-Directors, shall sign a conflict of interest statement annually. Any action taken by a Committee shall require a quorum of members present and be presented at the next meeting of the full Board of Directors.

2. Executive Committee. There shall be an Executive Committee, consisting of the officers of the Board, and three (3) additional members of the Board of Directors as desired by the Board. The Executive Committee shall have seven (7) members at all times and shall be representative of various stakeholder groups (consumers, employers, health plans, hospitals, physicians, and State government). The Executive Committee is empowered to act on behalf of the full Board when waiting for the next scheduled meeting of the full Board would jeopardize timely decision making or action. The Executive Committee shall have such o t h e r powers as the Board of Directors shall designate, except that the Executive Committee shall not have authority to adopt, amend or repeal the by-laws.

Each member of the Executive Committee shall serve at the pleasure of the Board. The designation of the Executive Committee and the delegation thereto of authority shall not relieve any Director of any responsibility imposed by law.

The Executive Committee shall be presided over by the Board Chair or his/her designee and shall oversee the operations of the DHIN and the Board of Directors. In addition, the Executive Committee shall evaluate the performance of the Chief Executive Officer and shall assist the Chief Executive Officer with leadership and management matters. The Executive Committee shall guide the development of and review and authorize personnel policies and procedures and is empowered to act on such personnel issues as may be brought forward by the Chief Executive Officer.

3. Finance Committee. There shall be a Finance Committee, which shall be presided over by the Board Treasurer and may consist of up to five (5) additional members of the Board of Directors as well as up to five (5) other individuals who have indicated an interest in the purpose and mission of the DHIN and have specific expertise to benefit the furtherance of the roles and responsibilities of the Finance Committee.

The Finance Committee shall have responsibility for overseeing the development of the budget, ensuring accurate tracking/monitoring/accountability for funds, ensuring adequate financial controls, reviewing major grant awards and contracts and their associated terms, overseeing development and implementation of the DHIN's sustainability and fundraising plans, identifying and soliciting funds from external sources for DHIN support, and planning and supporting audits of all major

functions (e.g. finances, programs, or organization). The Finance Committee will work with the Chief Executive Officer or other DHIN employee(s) as determined appropriate by the Board to accomplish its objectives

4. Board Development Committee. There shall be a Board Development Committee to support the development of Board policies and procedures and monitor needed changes or amendments to the by-laws. The Board Development Committee shall be chaired by the Secretary of the Board and may consist of up to seven (7) members as appointed by the Board Chair and approved by the full Board. The Board Development Committee shall be responsible for identifying needed board member expertise/skills; recommending potential members to the Governor for appointment; nominating Officers and Executive Committee members; orienting and training new members; ensuring effective board processes, structures and roles, including retreat planning, committee development, and board evaluation; and monitoring the need for ongoing Board training, education and informational activities.

5. Delaware Health Care Claims Database Administrative Committee. There shall be a Delaware Health Care Claims Database Administrative Committee (the “HCCD Committee”) of members of the Board, which shall consist of a minimum of five (5) members and a maximum of eleven (11) members to be nominated by the Board Chair and elected by the Board. The HCCD Committee shall be representative of various stakeholder groups (consumers, employers, health plans, hospitals, physicians, and State government). No more than one Director may serve from any one organization or agency from which that Director receives income or primary employment. A quorum of the HCCD Committee shall consist of the greater of three (3) members present or a majority of members present at a particular meeting. The Chair of the HCCD Committee shall provide a summary report of any actions taken to the next Board meeting, subject to any applicable confidentiality or other restrictions imposed by statute or regulation.

The HCCD Committee is empowered to act on behalf of the full Board with respect to the following actions:

a. Review of requests for Claims Data pursuant to the Health Care Claims Database statute, 16 Del. C. Ch. 103, *Subch. II* (the “HCCD statute”) and any regulations promulgated thereunder. The HCCD Committee shall authorize the release of Claims Data pursuant to the HCCD statute and regulations upon a determination by a majority vote of the HCCD that such release is appropriate to facilitate the purposes of the HCCD statute. Such determinations shall not be subject to the approval of the full Board.

b. Such other actions as the Board of Directors may designate.

6. Term of Office. Each member of a committee continues as such until his or her successor is

appointed, unless the committee is sooner terminated, or until his or her earlier death, resignation, or removal. All non-Director members of any committee may be removed by the Board Chair with the consent of a majority of the Board.

7. Rules. So far as applicable, the provisions of these by-laws relating to the conducting of meetings of the Board shall govern meetings of all committees. Each committee may adopt rules for its own governance provided that such rules are consistent with these by-laws and the DHIN's authorizing statute, 16 Del. C. Ch. 103.

#### ARTICLE IX - CONTRACTS, CHECKS, DEPOSITS AND FUNDS

1. Authorization. The Board of Directors may by resolution authorize any officer or officers, agent or agents or the Executive Committee, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the DHIN, and such authority may be general or confined to specific instances.

2. Loans. No loan shall be contracted on behalf of the DHIN and no negotiable papers shall be issued in its name unless authorized by the vote of the Board of Directors. When authorized by the Board of Directors so to do, any officer or agent of the DHIN may effect approved loans and advances at any time for the DHIN from any bank, trust company or other institution or from any firm or individual, and may make, execute and deliver promissory notes, bonds, or other certificates or evidence of indebtedness of the DHIN with respect thereto. Such authority shall be confined to specific instances. All bills, notes, checks, or other negotiable instruments of the DHIN shall be in the name of the DHIN and shall be signed by an officer of the DHIN or any other person duly authorized by the Board of Directors in such person's official representative capacity.

3. Checks, Drafts, Orders for Payment, Notes. All checks, drafts or other orders for payment of money, notes or other evidences of indebtedness issued in the name of or payable to the DHIN and any and all securities owned by or held by the DHIN requiring signature for transfer shall be signed or endorsed by such person or persons and in such manner as from time to time shall be determined by the Board of Directors.

4. Acceptance of Gifts. The Board of Directors or Executive Committee may accept on behalf of the DHIN any contribution, gift, bequest or devise for the general purposes or for any special purpose of the DHIN.

5. Audits. Upon affirmative vote of the Board of Directors, the accounts of the DHIN will be audited by a reputable independent accountant, whose report shall be submitted to each Director.

6. Bond. At the direction of the Board of Directors, any officer or employee of the DHIN shall be bonded. The expense of furnishing any such bond shall be paid by the DHIN.

#### ARTICLE X - NOTICE AND WAIVER

1. Notice. Except as specified in Article V, Section 5, which allows notice of meetings by fax or email, any notice required to be given under these By-Laws may be given by mailing the same, addressed to the person entitled thereto at his/her address as shown on the books of the DHIN and such notice shall be deemed to have been given at the time of such mailing. When delivered personally or by hand, the notice shall be deemed delivered when actually received.

2. Waiver of Notice or Lapse of Time. Whenever under the provisions of law or these By-Laws, the Board or any committee is authorized to take any action after notice to any person or persons or after the lapse of a prescribed period of time, such action may be taken without notice and without the lapse of such period of time, if at any time before or after such action is completed the person or persons entitled to such notice or entitled to participate in the action to be taken submits a signed waiver of notice of such requirement, or submits such waiver by electronic means in the case of a notice of a meeting as specified in Article V, Section 5.

#### ARTICLE XI - MISCELLANEOUS

1. Seal. The DHIN shall have no seal.

2. Fiscal Year. The fiscal year of the DHIN shall end on the 30th day of June in each calendar year or otherwise as the Board of Directors or Executive Committee may determine.

3. Annual Budget. The prospective, annual budget shall be provisionally approved by the Finance Committee prior to the end of each fiscal year and presented for approval by the full Board at the annual meeting.

4. Effective Date. These by-laws shall be effective as of January 25, 2017.

#### ARTICLE XII - INDEMNIFICATION

1. Right to Indemnification of Officers and Directors. The Officers, Directors, non-Director Committee members and employees of the DHIN shall have the right to indemnification to the extent set forth under Delaware law.

#### ARTICLE XIII - AMENDMENT

1. By-Laws. These by-laws may be altered, amended, or repealed by the Board at any regular meeting or at any special meeting called for that purpose; provided, however, that notice of the proposed amendment, alteration or repeal shall be given to each Director at least five (5) days prior to the date of the meeting at which the by-laws are to be altered, amended or repealed.

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**APPENDIX F**

**DHIN ACCOMPLISHMENTS**

# Delaware leads in health information exchange

## Saving time, money and lives



### Regional Footprint

Includes patient data from all or parts of six states and the District of Columbia



### Analytics Offerings

Putting data to work for health systems, government agencies, and large employers



**2.9 million**

Patients from all 50 states are included in the DHIN master patient index



**14 million**

Deliveries of clinical results and reports each year in Delaware



**150 million**

Clinical results and messages since inception



**\$7 million\***

The amount of savings realized with DHIN's annual results delivery

**\$10 million\***

In annual savings from fewer duplicate tests



**11,000+** professionals

In healthcare currently use DHIN in their day-to-day care of patients



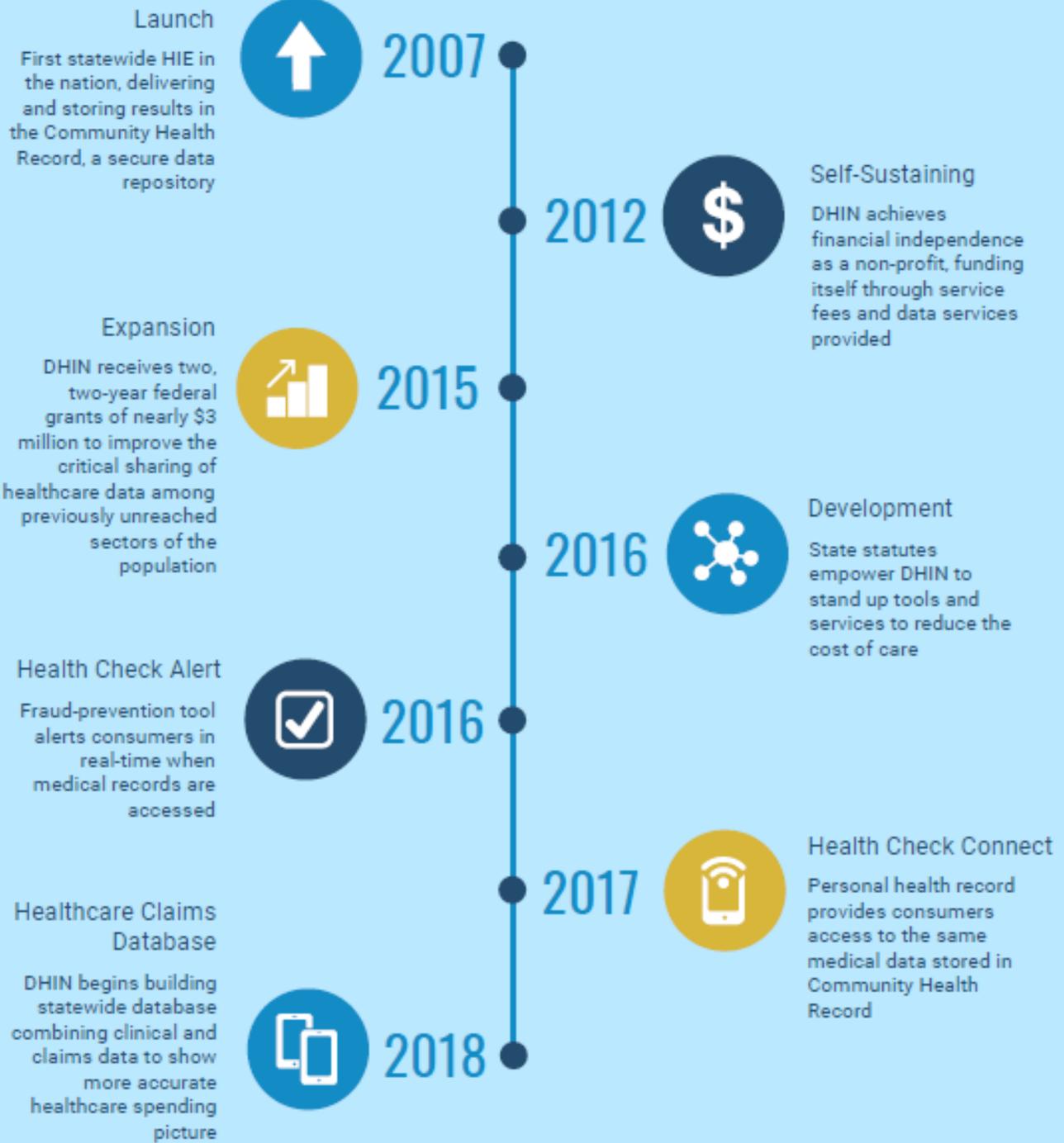
One of a select group of HIEs nationwide to receive HITRUST CSF Certification\*\*, the "gold standard" for measuring and certifying security management programs

\*October 2013 Maestro Evaluation, Delaware Health Information Network

\*\*HITRUST CSF Certified: DHIN Archive, DHINFTPS01, DHIN iSpecimen Prod, Medicity, and Managed Infrastructure

# A Decade of Health Innovation

Delaware Health Information Network (DHIN) saves time, money and lives.



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APPENDIX G

# FY 17 – FY 21 Strategic Roadmap (updated)

Initiative / Workstream	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
<b>DHIN Organizational Capabilities</b>					
1a Implement DHIN Change Management	→				
1b Align Human Capital Management with the DHIN's Strategic Direction	→				
<b>Customer Engagement and Marketing</b>					
2a Segment Customer Communications	→				
2b Perform Competitive Market Analysis		→			
2c Revise Client Segmentation, Marketing and Engagement / Sales Strategy		→			
2d Align Relationship Management Capabilities with Strategic Direction		→			
<b>Service Offerings</b>					
3a Recast Portfolio Management of Offerings	→				
3b Introduce Formal Service Offering Management		→			
<b>Enterprise and Solution Architecture</b>					
4a Align Technology and Services Sourcing Strategy		→			
4b Strengthen Architecture Planning and Governance		→			
4c Refresh Solution Architecture		→			
4d Acquire Cloud Services Brokerage as Foundation for HIE Cap. & Service Delivery			→		
4e Core Services Technology \ Services (Results, CHR) Re-procurement and Implementation		→			
<b>Service Operations and Management</b>					
5a Enhance Release Management Processes		→			
5b Implement Customer Service Level Management		→			
5c Strengthen Vendor Management Across Solutions		→			
5d Implement Cloud Service Brokerage and ITSM Framework Across Solutions		→			

- Active Workstream Efforts
- Ongoing Capability or Periodic Activity

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**APPENDIX H**  
**DHIN SERVICES**

DHIN services as published on website:



**Sharing Information, Promoting Communication**

The Delaware Health Information Network (DHIN) is taking our efforts to build a more complete health record to the next level, thanks to a sizable grant (grant number 90IX0001/01-00) from the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services.

Through this grant, DHIN is pleased to offer the following health communication tools to "eligible professionals" (those who are employed by a federally qualified health center and/or work with Medicare or Medicaid patients) home health and behavioral health organizations and long-term post-acute care (LTPAC) facilities.

**Adding Value to Your Practice - DIRECT Messaging**

For practices looking for a secure integrating solution, DHIN offers a statewide Health Information Service Provider (HISP) to safely and securely Direct message other providers through HIPAA-compliant, certified technology.

DHIN is currently offering to a limited number of practices a free trial period lasting through June 30, 2018. Please contact your DHIN Relationship Manager for details on this low-cost, turnkey solution that can help your practice improve secure data sharing and meet Meaningful Use requirements.

**Building the Patient Health Record - VorroHealth**

To improve transitions of care, DHIN has partnered with industry leader VorroHealth to assist with the transfer of clinical data. Through its clinical interface – BridgeGateHealth™ - VorroHealth allows for the easy transfer of clinical data from LTPAC facilities to DHIN's Community Health Record.

**Supporting Care Transitions - Care Summary (CCD) Exchange**

More than 50 practices working with EMRs like AllScripts, Amazing Charts, Athena, Cerner, Greenway and STI currently upload care summaries directly to the Community Health Record. This automated communications process is critical to building a better patient health record.

**Providing Patient Alerts - Event Notification System (ENS)**

Managing your patients' transitions of care is infinitely easier with DHIN's Electronic Notification System, alerting you to patient admissions, discharges and transfers across care settings. Subscribing practices receive alerts for patients treated by both Delaware and Maryland hospitals – and soon, Washington, DC.

*Eligible professionals, take note: Through grant funding, DHIN is able to offer both CCD exchange and ENS to your practice free of charge through July, 2017.*

**Putting Your Data to Work  
DHIN Analytics**

Today's data-driven healthcare system requires both access to and an understanding of meaningful patient data. Through DHIN, your practice or care team will soon have access to reporting and analytics tools that make population health management easier.



**Getting in Touch**

To learn more about DHIN's health communication tools, please contact your DHIN Relationship Manager or call 302.678.0220 for general information.

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DHIN services and pricing as submitted with JLOSC questionnaire responses:



## DHIN Services and Pricing Sheet

### DHIN Facts

The Delaware Health Information Network (DHIN) is a not-for-profit instrumentality of the State of Delaware with the statutory purpose to develop and operate a state-wide health information network integrating clinical, financial, and patient satisfaction data sources to inform decisions (16 Del Code § 10303). Expected benefits are improved communication within the healthcare community, improved efficiency and elimination of redundant testing, monitoring of population health and community health status, reduction in healthcare costs, and serving as the trusted source of information for consumers and purchasers as well as providers of care. DHIN is governed by a public-private board which includes individuals with various business, technology and healthcare industry skills committed to managing the Corporation in an efficient, effective and competitive manner. 16 Del. C. § 10302. DHIN is the state sanctioned provider of HIE services, and is the only public HIE in the state of Delaware.

DHIN's pricing and business model emphasize system usage and benefit. DHIN's diversified service lines are offered in both varied bundled packages to different Customer types to individual offerings which meet the specific needs of DHIN's Customer base. This document defines each service and provides use cases which illustrate the benefit of each service. Prices for each service are also provided. This document begins with the service bundles which are offered to DHIN's Data Senders, Payers, and Practices and then lists those services which are offered on an individual basis.

## Current DHIN Services and Capabilities:

### DHIN Data Sender Service Bundle

#### Electronic Clinical Results Delivery

DHIN facilitates the electronic transmission of clinical data from data sending organizations, such as hospitals, commercial laboratories and imaging centers to the ordering health care provider. Data senders include all of Delaware's acute care hospitals, three border hospitals in Maryland, all commercial laboratories and approximately 95% of imaging centers serving Delaware, as well as the Delaware Public Health laboratory. DHIN supports the receipt and delivery of laboratory and pathology results, radiology reports, a range of transcribed reports (such as hospital discharge summaries, history and physical examination reports, operative reports and various others), and ADT files (electronic hospital "face sheets"). Almost all health care professionals in Delaware who place clinical orders receive their results through DHIN. DHIN receives approximately 1.2 million unique results and makes approximately 1.5 million deliveries to practices each month.

### DHIN-to-EHR Integrations

As a special instance of Electronic Clinical Results Delivery, DHIN can interface to any electronic health record (EHR) capable of connecting via a web-service interface using Health Level Seven (HL7) standard language. The advantage of such an integration over other forms of results delivery is that the end user requires no special effort or actions to receive their results – they are delivered automatically into the EHR and accessible in the normal workflow of the user. Once DHIN certifies that a single interface to DHIN pulls all data types from all data senders and these results are stored and displayed correctly in that EHR, the vendor is free to market it as a DHIN-certified results delivery interface and sell it to all their clients who are DHIN members. There are currently certified results delivery interfaces from DHIN to 26 EHRs, representing 76% of EHR users in the state.

### Single Sign-On (SSO)

A user experience pain point for providers has been the necessity to authenticate into multiple systems while in the same user interface. DHIN partners with EHR vendors to solve this problem by allowing seamless access into the DHIN Community Health Record, using the authentication credentials of the EHR system.

### Care Summary Exchange

Providers and practices using certified EHR technology (CEHRT) are able to send to DHIN a summary of care using the C-CDA standard following each ambulatory visit. DHIN makes these available for viewing within the CHR as an additional data type, and provides reports to the sending practices on the number of views of this data for purposes of Meaningful Use reporting. DHIN will also shortly be making these summaries available to patients who enroll in the state-wide PHR/patient portal and provide Meaningful Use reporting to the sending practices on a range of consumer engagement objectives. DHIN is currently exploring the feasibility of using these care summaries as the source for clinical quality reporting on behalf of the sending organizations. At this time, approximately 13% of Delaware ambulatory providers have subscribed to this service.

### Clinical Gateway

For organizations which already have analytics tools and just need the data, DHIN is able to match incoming data from all sources against a watch list of patients provided by a subscribing organization and route a copy of the data to that organization, thus permitting them to apply their own tools for analysis. Large health systems can utilize this valuable data in support of their population health initiatives.

### Community Health Record

All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. This record can be queried by properly privileged users for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time and care settings is core to DHIN's value proposition. The Community Health Record

contains health data on nearly all Delawareans, as well as patients from all 50 states. In addition to information from Delaware facilities on Delaware patients, DHIN also receives information on Delaware patients from providers/facilities in other states.

*Out-of-State Connections:*

- DHIN and the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP) exchange ADTs based on the state of residence of the patient. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets.
- DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

Event Notification System

DHIN uses the ADT data coming from Delaware, Southeastern Pennsylvania, New Jersey, Maryland, West Virginia, District of Columbia, and Ohio hospitals, emergency departments, and participating walk-in clinics to match against a watch list of patients for whom a subscriber wishes to receive notifications. Notifications can be delivered real time or batched for delivery at intervals of the user's choice. Forty nine percent of Delaware residents are covered by a health plan using this service for purposes of outreach and care coordination. Approximately 17% of Delaware's ambulatory health care providers have also subscribed to this service for purposes of care coordination and transitional care management.

API to DHIN clinical data for use by their PHR

Many hospital systems and other data providers offer a Personal Health Record (PHR) for use by their patients to view information generated by the given health system. Typically though, the patient is only able to see information created by that health system. As a result, the patient is only able to see a limited amount of information, and if the patient wants to see more of their information, they would need create credentials and log in to another PHR system, creating frustration and dissatisfaction for the patient. DHIN offers the ability for the hospital to create an Application Program Interface (API) which links the hospital's system to DHIN's data repository and provides the ability to send patient information from all of DHIN's 26 primary data providers and out of state ADT providers to the hospital's PHR system so that the patient can view all of his/her information within the hospital's PHR setting, thereby creating hospital loyalty by the patient as they can view all of their information in that hospital's PHR system. In addition, patient satisfaction increases as he/she no longer needs to go to multiple PHR systems to obtain their information.

**Pricing**

DHIN provides bundled pricing for all 8 of these services based on the number of unique results sent by the data sender to the DHIN system.

Annualized Volume	Price per result
150,000 or less	\$0.235
150,001 to 2,400,000	\$0.320
Greater than 2,400,000	\$0.350

**DHIN Payer Service Bundle**

**Clinical Gateway**

For organizations which already have analytics tools and just need the data, DHIN is able to match incoming data from all sources against a watch list of patients provided by a subscribing organization and route a copy of the data to that organization, thus permitting them to apply their own tools for analysis. Health plans can use this data in support of their HEDIS reporting and population health initiatives.

**Community Health Record**

All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. This record can be queried by properly privileged users for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time and care settings is core to DHIN’s value proposition for payers. The Community Health Record contains health data on nearly all Delawareans, as well as patients from all 50 states. In addition to information from Delaware facilities on Delaware patients, DHIN also receives information on Delaware patients from providers/facilities in other states

**Out-of-State Connections:**

- DHIN and the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP) exchange ADTs based on the state of residence of the patient. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets.
- DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

**Event Notification System**

DHIN uses the ADT data coming from Delaware, Southeastern Pennsylvania, New Jersey, Maryland, West Virginia, District of Columbia, and Ohio hospitals, emergency departments, and participating walk-in clinics to match against a watch list of patients for whom a subscriber wishes to receive notifications.

Payers can receive notifications in real time or batched for delivery at intervals of the payer's choice. Forty nine percent of Delaware residents are covered by a health plan using this service for purposes of outreach and care coordination.

### Pricing

DHIN provides bundled pricing for all 3 of these services based on the number of covered members at a rate of \$0.75 Per Member Per Month.

## **DHIN Ambulatory Provider Services and Package Options**

### Services

#### Community Health Record Access

All clinical data from all data sending organizations is aggregated into a composite longitudinal record for each patient. This record can be queried by properly privileged users for both previously unknown patients and unknown data about a known patient. This aggregated view of the patient across geography, time and care settings is core to DHIN's value proposition. The Community Health Record contains health data on nearly all Delawareans, as well as patients from all 50 states, illustrating the well-known fact that we are a mobile society, and health care knows no borders.

#### Out-of-State Connections:

- DHIN and the Maryland state HIE, Chesapeake Regional Information System for Our Patients (CRISP) exchange ADTs based on the state of residence of the patient. CRISP also provides the infrastructure for HIEs for Washington, DC and West Virginia, which enables DHIN to receive ADT data on Delawareans who receive care in any of these markets.
- DHIN also exchanges information with NJSHINE, the HIE covering the southern counties of New Jersey, for similar exchange of ADTs based on state of residence of the patient.

#### Care Summary Creation and Download

As part of the Community Health Record, DHIN provides the ability to create a Continuity of Care document (CCD) from within the DHIN Community Health Record which includes all data from all data senders. The user may apply filters to limit the date range or specific data types to be included in the composite CCD. The resulting document may then be downloaded to the user's local environment, either in a pdf format, or as structured data if their EHR has the ability to consume it as such. Thus, even without an integration between DHIN and the user's EHR, the capability exists to incorporate data from the Community Health Record into the user's EHR and make it a part of their local record of care.

#### Event Notification System

DHIN uses the ADT data coming from Delaware, Southeastern Pennsylvania, New Jersey, Maryland, West Virginia, District of Columbia, and Ohio hospitals, emergency departments, and participating walk-

in clinics to match against a watch list of patients for whom a subscriber wishes to receive notifications. Notifications can be delivered real time or batched for delivery at intervals of the user's choice. Forty nine percent of Delaware residents are covered by a health plan using this service for purposes of outreach and care coordination. Approximately 17% of Delaware's ambulatory health care providers have also subscribed to this service for purposes of care coordination and transitional care management.

#### Care Summary Exchange

Providers and practices using certified EHR technology (CEHRT) are able to send to DHIN a summary of care using the C-CDA standard following each ambulatory visit. DHIN makes these available for viewing within the CHR as an additional data type, and provides reports to the sending practices on the number of views of this data for purposes of Meaningful Use reporting. DHIN will also shortly be making these summaries available to patients who enroll in the state-wide PHR/patient portal and provide Meaningful Use reporting to the sending practices on a range of consumer engagement objectives. DHIN is currently exploring the feasibility of using these care summaries as the source for clinical quality reporting on behalf of the sending organizations. At this time, approximately 13% of Delaware ambulatory providers have subscribed to this service.

#### State-wide Patient Portal/Personal Health Record (PHR)

Because DHIN receives data from many sources, it is uniquely positioned to provide patients/consumers with access to their personal health data with minimum effort. For practices that have already implemented a patient portal, an API connection to the DHIN data repository allows data from all sources to be retrieved and presented upon patient login to the hospital or practice portal. For those who have not yet implemented a portal, DHIN offers a co-branded implementation of the tool we are calling "Health Check Connect." This not only provides access to the data in the DHIN data repository, but offers additional features and functions, to include secure messaging between providers and patients, patient education resources, and interfaces to various medical devices, such as digital scales, glucometers, blood pressure measuring devices, exercise/activity trackers, and others. The patient will have the option to select their language preference when they set up their account. At launch, supported languages will be English, Spanish and Romanian, with plans to add others as fast as translators can be found to assist with the mapping.

**Package Options and Pricing**

DHIN offers several services to ambulatory practices which are available in a variety of packaged options. Practices are financially encouraged to send CCD information into the DHIN in order to patient information with the entire Delaware Healthcare Ecosystem. Practices receive an equivalent discount of \$200 annually by sending in their patient CCD records to the DHIN.

**Providers - Package Options**

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
CHR Access	X	X	X	X	X	X	X	X
ENS			X		X		X	X
CCD Exchange		X			X	X	X	X
PHR Portal				X		X	X	X
Not Signed Off								X
Price - per practice	\$400	\$200	\$500	\$500	\$300	\$300	\$400	\$800

**Additional Services Offered Individually**

In addition to aforementioned services, DHIN offers the following services to its Customer base.

**Medication History**

This is a value-added subscription service which allows a user of the CHR to retrieve 12 months of prescription fill history (provided by a number of national sources, to include SureScripts, health plan pharmacy benefits managers, and others) upon demand. For those who do not choose to subscribe to the full service, there is a URL link embedded in the DHIN web portal that takes the user to the Delaware Prescription Monitoring database, where they can at minimum (and for no charge) view the controlled substance fill history for the patient.

**Price** - \$330 per year per provider.

**PACS Image Sharing**

St Francis Hospital, Mid-Del Imaging, and Nanticoke Hospital have implemented an image sharing service through DHIN. URL links are added to the radiology reports sent into the DHIN Community Health Record. These links interface with the source imaging system or an offline cache of recent

images, giving providers the capability to view images from the DHIN CHR portal, and even compare with previous studies. The three currently participating data senders account for 11% of all imaging results sent into the Community Health Record, and span the three counties of the state.

**Price** - \$.20 per study stored by DHIN.

#### DHIN Electronic Public Health Reporting

DHIN connects to the state's public health electronic lab reporting system for real-time delivery of reportable diseases. Through the emergency department (ED) admission transactions, DHIN receives the relevant lab report for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

**Price** – Charged out on a project basis, subject to annual review based on DHIN's support and project management over the course of a given year.

#### DHIN Electronic Syndromic Surveillance Reporting

DHIN connects to the state's public health bio-surveillance system for real-time delivery of emergency chief complaint data. Through the emergency department (ED) admission transactions, DHIN receives the relevant chief complaint for the patient's visit and routes it to the patient's provider, as well as to the Delaware Electronic Reporting and Surveillance System (DERSS) in real-time standardized format. By state regulation, all Delaware hospitals must send this data through DHIN to Public Health, using the most current technology standards.

**Price** – Charged out on a project basis, subject to annual review based on DHIN's support and project management over the course of a given year.

#### DHIN Immunization Registry and Query

DHIN provides a web-service that enables both electronic reporting to and query of the state immunization registry, DelVax. Automating the submission of this data electronically through a web service interface improves reporting timeliness and accuracy and results in a more up-to-date record of each patient's immunization status. Currently, this service is used by 100% of Delaware hospitals, 77% of Delaware pharmacies, and 32% of ambulatory practices, with many more in various stages of testing or onboarding.

**Price** – Charged out on a project basis, subject to annual review based on DHIN's support and project management over the course of a given year.

#### DHIN Newborn Screen Electronic Reporting

Newborn screening consists of early hearing detection and a set of lab tests for early detection of harmful metabolic and congenital conditions. DHIN has worked with Public Health and the state's hospitals and birthing centers to enable the electronic reporting of early hearing detection testing through DHIN to Public Health. DHIN is currently working with Public Health to automate combining the

results of the hearing detection and metabolic screening into a composite newborn screening report that can be delivered by DHIN to the birth hospital and the provider who will be caring for the baby.

**Price** – Charged out on a project basis, subject to annual review based on DHIN’s support and project management over the course of a given year.

#### Consulting Services

DHIN has provided consulting services to the state of Hawaii in standing up their HIE, and has provided varying levels of consulting support to other states on specific topics.

**Price** – Charged out on a per engagement basis.

**Direct Secure Messaging** – This service enables secure, encrypted point-to-point exchange of information between individual entities or organizations which have established a trust relationship, using the ONC-adopted standard for such communication. Many but not all providers receive this service directly from their EHR vendor, but DHIN offers the option for users to subscribe to this service through us if they do not already have access to it from other sources. We have a few subscribers among organizations not yet using an EHR, to include paper-based practices and provider types not eligible for the CMS EHR Incentive Program (primarily behavioral health and long term and post-acute care organizations. Adoption of this service is low.

**Price** – TBD

**Specimen Location for Research** – This service enables DHIN to connect researchers looking for biological specimens (blood, serum, tissue, etc.) meeting specified parameters with laboratories holding specimens meeting those parameters. With patient consent, once biologic specimens have been used for the intended clinical purpose, the residuals which remain and would otherwise be discarded can be made available to researchers under IRB-approved research protocols.

**Price** – 75% of Specimen reimbursements are credited to the given hospital’s Results Delivery payment.

#### Analytics/Reporting Service

DHIN has recently launched an analytics and reporting service, used primarily by ACOs who seek to understand the activity of their patients outside their own network. Because DHIN receives data from all hospitals, labs, and nearly all imaging centers as well as a small but growing number of ambulatory practices and urgent call centers/walk-in clinics, DHIN is uniquely positioned to provide this service.

**Price** – Customized on a per engagement basis.

#### Clinical Gateway

For organizations which have analytics tools and just need the data, DHIN is able to match incoming data from all sources against a watch list of patients provided by a subscribing organization and route a copy of the data to that organization, thus permitting them to apply their own tools for analysis. Users of this service include large health systems in support of their population health initiatives, and health plans in support of their HEDIS reporting.

**Price** – Customized on a per customer basis.

#### Fraud Detection

DHIN’s “Health Check Alert” service allows subscribing patients receive a text message alert whenever new data is received by DHIN about them, or whenever a user accesses their information in the Community Health Record. Similar to the processes used by credit card companies for fraud alerts, the patient then sends a simple reply indicating whether they do or do not recognize the activity as legitimate. Additional benefits to the patient include the knowledge of who is accessing their health data, and awareness of when test results are available, both to the ordering provider and to the patient directly through a patient portal/PHR. Health plans are also target customers as receiving notifications from their patients about an incorrect transaction allows them to pursue any potential fraudulent activity before the claim is paid.

**Price** – TBD

## **DHIN Functionality Currently Under Development:**

#### Health Care Claims Database (HCCD)

The Delaware General Assembly passed legislation in 2016 authorizing DHIN to stand up a Health Claims Database. Reporting to this database will be required for Medicaid and state employee health plans, qualified health plans on the Marketplace, and federal sources such as Medicare. Other health plans may report data on a voluntary basis. Broad use cases contemplated include support for population health initiatives, provider risk sharing, and consumer shopping. DHIN has recently completed a successful proof of concept and began receiving data in May of 2018.

#### Medical Orders for End-of-Life Care

The Delaware General Assembly has enacted legislation to establish a common form and accompanying policies and procedures to incorporate patient end-of-life care preferences into a concise set of medical orders (DMOST) which must be honored across the state in all care settings. DHIN is authorized to establish a registry for these orders. We are currently working with the DMOST working group to develop and implement this registry.

## **DHIN Functionality – Future Plans**

#### Mental Health/Behavioral Health Data Exchange

Exchange of mental health data requires more than the usual privacy and security tools. DHIN currently is able to support the granular patient consent that is necessary to restrict viewing of behavioral health data to specific individuals the patient has consented to have such access. Few behavioral health organizations in Delaware currently use electronic health records, but as this number grows, there will be value in including such data in the Community Health Record.

### New data types and data sources

The social value of the Community Health Record as well as the value of the DHIN data repository is greatest if all the data are “in” and all the healthcare community is using it. The value can be augmented with the addition of:

- Ambulatory data – DHIN expects to continue a focus on the goal of widespread CCD contributions from the ambulatory setting. Currently, approximately 13% of DE providers contribute such data.
- Claims data – many elements of a claim are useful proxies for clinical information, such as procedure and diagnosis codes, as well as a complete listing of providers seen and medications filled. DHIN has a data use agreement with the dominant carrier in our market, but we have not yet implemented the data feeds for the use of incorporating this data for clinical use.
- Medical device data – EKGs and other devices with output which is graphic or pictorial rather than primarily text or number based, as well as home glucometers and scales would provide very valuable additions to the Community Health Record and enhance care across the care continuum.
- Data from the long term and post-acute care (LTPAC) organizations – These data sources are very important to support the analytics needs of ACOs and providers considering entering into risk-bearing contracts. A small but growing number of LTPAC organizations use electronic health records, but a solid business case to entice them to participate in the information exchange ecosystem has been elusive. DHIN will continue efforts to engage this important group.

### Care Gaps

Based on accepted clinical guidelines and using all data from all sources contained in the DHIN repository, DHIN would provide notification of possible gaps in care to enable proactive case management and care coordination.

### Risk Stratification

Identify high risk patients for special care coordination. This is a necessary activity under some of the newer delivery and payment models, such as Patient Centered Medical Home. The cost of providing this service could be reduced if a single tool and set of risk stratification algorithms is used across the state.

### Clinical Quality Measure Reporting

Practices may be reporting under multiple programs, such as Meaningful Use, MIPS, and to one or more health plans. DHIN could be the clearing house such that the practice submits all measures once to DHIN, and DHIN reports out to the various end points. DHIN aspires to become a Qualified Clinical Data Registry for this purpose.

## Discontinued Services

### Common Provider Scorecard

Under one of the initiatives of the State Innovation Model (SIM) grant received by Delaware, the major carriers and health plans have agreed on a common set of clinical quality measures, utilization metrics and cost metrics and they report this data to DHIN quarterly. DHIN then publishes a Common Provider Scorecard which enables subscribing providers to see their performance on these measures across their entire practice and also stratified by payer and health plan.

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