DELAWARE HEALTH AND SOCIAL SERVICES

Cut Paperwork, Not Care

Health care's missing utility infrastructure - starting in Delaware, open to every state

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Chair, Delaware Health Care Commission

Prior Authorization Call - Recorded May 15, 2026

Dr. Hockstein: So, you're looking at Open Evidence because you're unfamiliar with the problem that the patient has, and you're doing the prior authorization for this problem.

Reviewer: Well, if you had... so, one, we didn't have any clinical information. So, reviewing the case anyway.

Dr. Hockstein: Well, you had my note. You did have my note.

Reviewer: We did not have your note.

Dr. Hockstein: You don't have my note. You have no clinical information on this patient?

Reviewer: Um, I have nothing attached to this patient's, um, claim - you know, requests - and this is why we said we could not approve the request, because we do not have enough information of the symptoms, um, required, um, for approval. And so we didn't have, um, the documentation, which was what was in the denial rationale or denial note.

Dr. Hockstein: So it was denied without asking for additional information?

Reviewer: Well, um, so I don't... So, basically, here we are. What information do you have today?

The scale of the problem

9 in 10
physicians say prior auth delays care

13 hrs
per practice, per week, on prior auth alone

$1T
a year in U.S. administrative spending

9 billion faxes a year

"We'd love to approve this - can you fax us the clinical notes?"

Two systems that don't connect. Patients an afterthought.

The clinical system has the record.
The administrative system has the request.
The patient is stuck waiting between them.
When the tracks don’t connect, staff print, upload, fax, scan, re-key, and chase.

Clinical systems

EHRs hold the facts: symptoms, history, imaging, notes, and the treatment rationale.

Administrative systems

Payer workflows hold the request: member, coverage, code, rule, status, and decision.

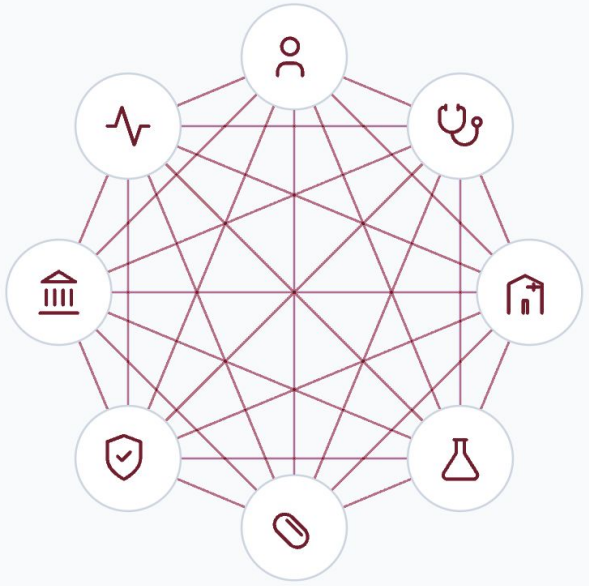
Patient

The person whose care is waiting usually has little visibility into either side of the handoff.

The note wasn’t missing. The bridge was missing.

From N×N to N×1

N × N



Every party connects to **every** *other party. Thousands of point-to-point integrations.*

N × 1

Every party connects **once.**
The Hub routes — and stays payload-blind.

From a tangled web to a common hub

Modern APIs alone do not fix fragmentation.

If every plan connects separately, the fax tangle just becomes an API tangle.

Now is the moment

A rural health crisis - and a CMS deadline

Rural providers and hospitals are under real financial strain - and continued RHTP funding depends on showing CMS a credible plan you're actually implementing.

Prior-auth burden - and 2027 deadline

CMS-0057 mandates electronic prior authorization by January 2027.

If each plan builds separately, providers still face a plan-by-plan tangle - compliance without relief.

Streamline Medicaid; prove integrity

Do more with less: cut administrative cost and get payment right the first time (coordination of benefits) - as accuracy, not gatekeeping.

The choice: join shared national infrastructure - not build another state silo.

Delaware RHTP Initiative 15: Statewide Health IT Infrastructure for Real-Time Insurance Verification & Prior Authorization

"this initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN"

Outcomes by Year 3:

- 75% reduction in prior auth response times
- 85% clean claims rate
- 90% reduction in first pass claim denials

Funding: $50m over 5 years

Sustainability plan: Fully self-sustaining through a utility fee model of 0.05% of revenue equally applicable for all payer and provider participants - including state agencies, state Medicaid programs, rural and non-rural healthcare providers, and public and private insurers.

What the hub does for Medicaid & States

Prior authorization

Faster decisions, fewer coverage-error denials, and CMS-0057 readiness through one shared implementation pattern.

Eligibility + COB

Surface coverage earlier so Medicaid is correctly the payer of last resort - payment accuracy, not access.

Rural access

Connect rural providers once, reduce phone-and-fax work, and increase rural back-office staff efficiency.

Accurate payment

Cleaner claims and fewer reworks mean faster payment - easing cash-flow pressure on thin-margin rural providers.

Four wins on the same rails: prior auth; accurate payment, rural access, and transparency.

What changes for the patient

Today

The prior authorization happens between payer and provider. The patient waits in the dark - often learning a request was even made only when it is denied.

Through the hub

The patient sees status in real time - what was submitted and what was decided - and keeps an audit history for any appeal, subject to privacy and safety rules.

The result

Care moves faster, billing surprises shrink, and the person whose care is waiting is no longer the last to know.

The patient is a party to the transaction, not an afterthought.

What this is not - and what it is

It is not

- Not a clinical data warehouse - data stays at the source
- Not payer-owned or vendor-owned - no transacting party owns it
- Not a new Medicaid eligibility or work-requirements system - it moves verified facts, not coverage decisions
- Not a rip-and-replace of your state systems or EHRs
- Not an HIE replacement - it leverages and helps sustain your HIE
- Not another RHTP line item - it's the shared rails that enable your VBC, coordination, and workforce initiatives

It is

- Neutral, shared plumbing for administrative transactions
- A neutral hub connecting payers, providers, and patients once - encrypted, no pooled records
- Built on the standards your systems already run on (FHIR, X12)
- A state-led pattern Delaware is proving first
- All-payer infrastructure Medicaid can help catalyze
- Governed for neutrality - no one party can own or capture it

It's plumbing, not another program - the 3-way rails underneath the rest of your RHTP plan.

How the network is governed

Governance Council

The rules. Sets standards, certifies participants, and can veto operator changes; states have representation.

Public Benefit Corporation

The operator. Runs the rails under a public-benefit duty; investor returns capped, surplus reinvested.

Data Trust

Patient fiduciary. Enforces consent and patient data rights; no data monetization.

Foundation

The commons. Funds the shared public-good layer, benefiting all.

Delaware: the proving ground

Signed. Funded. Moving.

The Delaware commitment

$50M over five years through RHTP Initiative 15 to stand up the Smart Health Network with DHIN as the state HIE partner - strengthening the HIE while scaling it.

Test it now

The sandbox (July 6) and the Delaware Connectathon (July 13) are open to every state - free, synthetic data, no obligation. Bring a team, run live prior-auth, and leave with a proof pack for CMS.

www.smarthealthnetwork.org/connectathon

You can move fast: CMS progress by September, prior auth by January

Stand it up fast

The network already exists - you deploy, not build. Adapt Delaware's RHTP template to your state’s requirements. Subsidize quick rural provider adoption.

Activate the market

Pull the levers you have with payers - Medicaid MCOs, state employee plan, Insurance Commissioner - and the market will follow.

Prove progress

Testing by September shows CMS real progress this year. Full prior-authorization readiness by the January 1 deadline.

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Delaware is going first, and inviting every state to join us.

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