



Policy Brief

CDC Request for Information on Data Intermediaries – Insights for Civitas Members

The Centers for Disease Control and Prevention (CDC) recently published a Request for Information (RFI), *Data Intermediaries and Approaches to Strengthen Public Health Data Exchange* (Docket CDC-2026-1519), seeking public input on how data intermediaries can support secure, scalable, standards-based public health data exchange. Comments are due November 20, 2026.

Over the past year, Civitas has worked closely with the CDC Office of Public Health Data, Surveillance, and Technology on the capabilities and public health use cases of data intermediaries such as HIEs, HDUs, and CIEs. This RFI gives Civitas members a direct opportunity to describe how they support public health data exchange today and the role they can play as the CDC shapes its approach. Civitas recognizes the substantial public health data modernization work already underway at the CDC, in state, tribal, local, and territorial health departments, and with partners such as ASTHO, and the RFI asks how intermediaries can support and build on that work. FY27 appropriations language also directs the CDC to leverage data intermediaries to route data between providers, health departments, and the CDC, and the questions in the RFI bear on how that direction could be carried out. Civitas plans to submit a comment letter grounded in member experience, and this brief summarizes what the CDC is asking and outlines how members can contribute.

What The CDC Is Asking

The CDC describes progress through its data modernization investments, including electronic laboratory and case reporting and the One CDC Data Platform, and says siloing and interoperability challenges still limit public health's ability to respond, pointing to the evolution of HIEs, the emergence of HDUs, TEFCA, and the CMS Digital Health Tech Ecosystem as an opportunity to examine how intermediaries can together enable more timely and scalable exchange.

The CDC states that the framework it is developing is intended to help public health organizations specify, select, and evaluate intermediary capabilities. The capabilities placed in the baseline, and the way intermediaries are assessed against them, will depend on how public health agencies approach intermediary partnerships. The RFI also asks how shared infrastructure should be sustained beyond initial implementation and how implementation can build on existing infrastructure without unnecessarily replacing it, which relates to the FY27 appropriations direction noted above. The CDC's definition groups HIEs and HDUs with national networks and other intermediary types, and several questions ask respondents to note differences by type, including how governance should vary by function, data, and jurisdiction. The RFI does not state when the CDC expects to finalize the framework or whether it will lead to funding opportunities or requirements, so the comment record is the main input available at this stage. The context the CDC provides for each section and the questions it asks are summarized below.



A. Definition

CDC defines a public health data intermediary as a trusted organization, network, platform, or governed service that provides shared technical, operational, and governance capabilities for exchanging and stewarding health-related data with public health authorities while protecting privacy. Intermediaries can be centralized or decentralized, operate at local levels through national scale, and receive data from providers, payers, laboratories, pharmacies, and non-traditional sites such as schools. CDC names HIEs, HDUs, TEFCA, Qualified Health Information Networks, CMS-Aligned Networks, Health Center Controlled Networks, and public health data hubs as examples.

While CIEs are not explicitly itemized in the primary definition or example list, the RFI broadly invites input from community engagement capabilities, social service organizations, and entities addressing health-related social needs, as they are important to public health data modernization efforts.

Question	What CDC is Asking
II.A-1	How does this definition of “public health data intermediary” align or conflict with other established definitions, or on-the ground experiences, used across public health and health IT, and what changes would improve distinction or alignment?

B. Standards and Technical Capabilities

CDC is developing a Public Health Intermediary Framework with three layers: a universal baseline of core capabilities and safeguards, service-specific profiles (such as routing, record linkage, terminology management, or analytics), and public health use-case profiles (such as electronic case reporting, electronic laboratory reporting, immunization, syndromic surveillance, or emergency response). Expectations may also vary by maturity level, and the questions below ask what should sit in each layer and how intermediaries should be assessed.

Question	What CDC is Asking
II.B-1	Which capabilities, functions, use cases, and data sources intermediaries support today, where they offer advantages over direct exchange, and where they add cost, complexity, or risk.
II.B-2	Which capabilities belong in the baseline versus the profiles across data quality, routing, security and trust (including consent enforcement), and reliability, with specific minimum requirements.
II.B-3	How intermediaries should be assessed, including testing, certification, and existing tools.
II.B-4	How a maturity model could work and what evidence should be required to progress.
II.B-5	How artificial intelligence may affect intermediary roles.

C. Funding and Sustainability

CDC states that shared infrastructure requires funding beyond initial implementation to cover ongoing operations, maintenance, governance, security, and scalability, and it seeks input on how financial responsibility for that infrastructure should be allocated.



Question	What CDC is Asking
II.C-1	Current funding sources for public health services, who bears the costs, and who receives the benefits.
II.C-2	Funding models most likely to sustain and scale services, with examples from current practice.
II.C-3	How fees and onboarding could reduce barriers for rural providers, small laboratories, under-resourced jurisdictions, tribal entities, safety-net providers, and community-based organizations.
II.C-4	Funding and contracting approaches CDC could use to promote portability, competition, and open standards while avoiding vendor lock-in.

D. Governance

CDC applies the same layered approach to governance, with a universal baseline and service-specific and jurisdictional profiles, so that requirements scale with the functions an intermediary performs and the laws that apply to it. It asks respondents to consider delegated authority, participant obligations, permitted and prohibited uses, audit and oversight rights, dispute resolution, corrective action, and continuity.

Question	What CDC is Asking
II.D-1	Accountability expectations and whether they should vary by function, data, or jurisdiction.
II.D-2	Safeguards against conflicts of interest, biased routing, vendor lock-in, and market concentration.
II.D-3	What should govern an intermediary's authority to receive, route, transform, and disclose data.
II.D-4	Oversight roles for CDC, other federal agencies, state, tribal, local, and territorial authorities, and intermediary governing bodies, and appropriate corrective-action mechanisms.
II.D-5	How governance can accommodate differences in law, consent, and data use agreements.

E. Implementation

CDC seeks input on the assistance, readiness conditions, and partnerships needed to integrate intermediaries into public health data modernization, and it asks respondents to describe their intermediary type, jurisdiction, size, technical maturity, and primary use cases.

Question	What CDC is Asking
II.E-1	Tools and templates agencies need to evaluate, select, and oversee intermediaries.
II.E-2	Barriers to agency readiness and how implementation can build on existing infrastructure through coexistence, migration, or transition.
II.E-3	How pilots and learning collaboratives could test and scale promising models.
II.E-4	What public health could offer providers, payers, and laboratories through intermediaries to create shared value.



II.E-5	Where CDC can add the most value (as convener, funder, purchaser, technical assistance provider, or evaluator) and where it should defer to existing efforts.
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F. Evaluation

CDC seeks input on how to evaluate the framework over time and states that evaluation should be feasible, limit reporting burden, account for unintended consequences, and inform decisions to sustain, modify, expand, replace, or discontinue approaches.

Question	What CDC is Asking
II.F-1	Where CDC can add the most value as an evaluator.
II.F-2	Measures for evaluating the framework, including workflow and workforce burden, data usability, and response capacity.
II.F-3	How to assess value and cost efficiency, including who bears costs and unintended effects such as cost shifting.

Next Steps

Civitas will submit a comment letter by the November 20, 2026 deadline, and members are invited to share input on any of the questions. Please send any feedback to Karen Ostrowski by October 30th. In developing the letter, Civitas will also work closely with our Public Health Workgroup, HDU Steering Council, and HIE and HDU members, as well as partners at ASTHO, to gather input and promote consistent messaging across the organizations CDC is hearing from. Members are welcome to submit their own comments to CDC through [regulations.gov](https://www.regulations.gov), and because comments become part of the public record, members should avoid including confidential information in anything they file.