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Jun 16, 2025

Dr. Mehmet Oz
Administrator
Center for Medicare & Medicaid Services

Dr. Thomas Keane
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology

Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Response to Request for Information (RFI) on the Health Technology Ecosystem

Dear Drs. Oz and Keane

On behalf of Findhelp, we appreciate the opportunity to respond to the RFI on the health technology ecosystem. We commend the Departments for their commitment to leveraging technology to advance value-based care, improve health outcomes, and empower patients and caregivers.

Findhelp operates the nation's leading closed-loop social care referral system. Our platform is used by hundreds of healthcare organizations, government agencies, and community-based organizations (CBOs) to connect people to social services like food, housing, and transportation. Our mission is to connect people in need and the programs that serve them, with dignity and ease.

Our responses to the specific questions outlined in the RFI are provided below.

PC-1. What health management or care navigation apps would help you understand and manage your (or your loved ones) health needs, as well as the actions you should take?

Effective health management requires digital tools that bridge the clinical and social care sectors. Our experience shows that the most critical function is a social care network with closed-loop referral capabilities. This provides user-friendly access to a verified network of community resources, enables closed-loop referrals to confirm services were rendered, supports shared care planning, and ensures privacy through clear, patient-centric consent models. These social care systems must be interoperable with EHRs and HIEs to provide a seamless experience for all users.

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PC-4-b. What set of workflows do you believe CMS is uniquely positioned to offer?

CMS is uniquely positioned to establish foundational privacy rules for social care data that are a condition of program participation. This will create a trusted ecosystem for whole-person care. Findhelp's unwavering policy is that we do not sell the data of people seeking help. **We urge CMS to make this the industry standard by using its regulatory and payment authority to require:**

- **Data for care, not for commerce:** Social care data collected for care coordination cannot be sold to or by data brokers, or used for unrelated commercial purposes.
- **Purpose-driven consent:** A requirement for clear, explicit patient consent before social care data is shared.
- **Certification standards:** A certification program for social care platforms, similar to the one for EHRs, to ensure baseline privacy, security, and interoperability standards are met.

PC-8. In your experience, what health data is readily available and valuable to patients or their caregivers or both?

The most valuable data is a longitudinal record that includes both clinical and social care histories. A record showing a patient's high A1c is useful; a record showing a high A1c *and* recent referrals to a food pantry provides context for effective interventions. Our platform captures and structures social care data. When integrated with an EHR, this information is essential for risk stratification, proactive care planning, and success in value-based care. For patients and caregivers, this data validates their lived experience and ensures the care team is aware of their real-world challenges.

PC-10. How is the Trusted Exchange Framework and Common AgreementTM (TEFCA™) currently helping to advance patient access to health information in the real world?

TEFCA's greatest potential is to facilitate the exchange of diverse health-related data, most notably social care information. While TEFCA implementation is in early stages, it is already advancing patient access with the common trust and technical framework needed for networks to connect. This provides a pathway for social care networks and CBOs to become trusted participants in the national health data ecosystem. For example, adopting TEFCA standards simplifies the secure exchange of referral outcomes between a social care platform and a hospital EHR. We urge HHS, ONC, and CMS to continue prioritizing and incentivizing TEFCA for SDoH data exchange, and ensuring that connectivity and data exchange remain vendor-agnostic.

PC-11-d. What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange?

As TEFCA is adopted, HIEs can evolve into specialized hubs for regional data interoperability. This infrastructure can be leveraged for social care data exchange. Key HIE responsibilities should be:

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- **Longitudinal records:** HIEs are uniquely positioned to support social care data exchange alongside healthcare data, with the appropriate consent and permissions. Successfully joining these data sets supports the whole-person care approach being undertaken by healthcare providers and CBOs.
- **Data aggregators:** HIEs can be regional hubs for aggregating clinical data from QHINs with local social care data, public health data, and claims data, providing a more comprehensive community record.
- **Technology neutrality:** HIEs must remain impartial to the technologies used by hospitals, health plans, and CBOs, and should not enter into exclusivity agreements with vendors. This aligns with the HIE's historically neutral role and fosters a competitive, innovative market.
- **Receiving data signals:** HIEs should be positioned to receive standardized social care data from interoperable platforms. They should not, however, act as the primary router for social care referrals. Expecting HIEs to manage referral workflows and permissions complicates privacy and limits CBO choice.

PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem?

While the healthcare ecosystem has benefited from certification programs that ensure secure, standards-based data exchange, a similar framework does not exist for the landscape of technologies in behavioral health, post-acute, and social care. This "wild west" of digital tools outside the hospital creates a significant gap in our ability to connect a person's entire health journey. Closing this gap is essential to transforming health.

We recommend that CMS and ONC/ASTP champion policies that drive modern standards adoption for all health-related technology. With requirements for adopting FHIR standards, meeting baseline security protocols, and supporting open APIs for exchanging referrals, CMS can lift up these other sectors to be interoperable partners with healthcare.

TD-4. How can CMS better encourage use of open, standards-based, publicly available APIs over proprietary APIs?

CMS can directly encourage the use of open APIs by making it a prerequisite for participation in federally funded initiatives. For example, requiring the use of certified, open APIs to receive funding through CMS waivers or other value-based care programs would create a powerful incentive for vendors and providers to abandon proprietary models and embrace a more collaborative, standards-based approach.

Findhelp is committed to an open, standards-based approach to interoperability. Our platform utilizes publicly available APIs to ensure flexible, secure, and sustainable connections with our partners. We believe proprietary APIs create vendor lock-in, increase costs, and stifle the innovation needed to build a responsive, whole-person care ecosystem.

TD-7. To what degree has USCDI improved interoperability and exchange and what are its limitations?

The USCDI framework has been valuable for standardizing the exchange of key data elements, allowing systems to understand that something happened—for example, that a new diagnosis was made or a social care assessment was completed. Knowing these facts is an important foundation for interoperability.

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However, the primary limitation of USCDI is that it is not designed to support the transactional layer of interoperability required for actual care pathways. It documents an event but does not standardize the real-time, bidirectional communication needed for workflows like scheduling or referrals.

Our integration with partners like Epic demonstrates this point. We use an open, FHIR-based API framework to support the interoperability of social care referrals at the transaction layer. This allows a referral to be initiated within a clinician's EHR workflow and be routed seamlessly to the correct CBO using our platform, with status updates returned to the EHR. This critical transactional workflow occurs outside the scope of USCDI and is essential for closing the loop on care.

TD-9. Regarding certification of health IT

Redefining certification to prioritize API-enabled capabilities over proscriptive software functionality would be highly beneficial, particularly for standardizing communication with vendors supporting CBOs, post-acute, and behavioral health organizations. An API-first certification model would create a standardized, secure "on-ramp" for data exchange across the entire health ecosystem. It would allow diverse organizations—from small CBOs to large post-acute providers—to participate in interoperability by adopting certified APIs without forcing them into a monolithic software model that doesn't fit their unique workflows. This approach fosters innovation in software functionality while ensuring a common language for communication, which is the ultimate goal of certification.

TD-14. Regarding networks' use of FHIR APIs

Findhelp actively uses and advocates for FHIR as the fast, secure, and modern standard that enables the granular, real-time data exchange necessary for closed-loop referrals. Our network connects to hundreds of endpoints across the country through our partnerships, using open APIs to facilitate data sharing. We are currently implementing FHIR-based data exchange, including the use of FHIR Bundles, to support large-scale initiatives such as the New York 1115 waiver.

Increased use of bulk FHIR APIs would further improve data flow, particularly for population-level analytics, public health reporting, and managing social care needs across large patient panels in value-based care arrangements. The primary challenge of bulk FHIR is ensuring that the robust privacy and consent management needed for such large-scale data transfers are meticulously implemented.

TD-16. What are the tradeoffs of maintaining point-to-point models vs. shared network infrastructure?

When open standards like FHIR are widely adopted, a landscape of point-to-point connections removes central bottlenecks and fosters a competitive, innovative ecosystem. It allows organizations to be flexible and creative, preventing the formation of monopoly arrangements that can result from over-investment in a single shared utility..

To improve alignment and encourage scalable network participation, we recommend that CMS expand its efforts around provider directories to the non-clinical space. By championing a national human services taxonomy—building on the foundational work of initiatives like the Gravity Project, of which we are a part—CMS could establish a FHIR-based

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framework for the entire human services sector. This would create a standardized way to identify and connect with community partners, making point-to-point integration dramatically more efficient and scalable.

TD-17. Given operational costs, what role should CMS or ASTP/ONC or both have in ensuring viability of healthcare data sharing networks, including enough supply and demand, that results in usage and outcomes?

CMS and ASTP/ONC have a critical role in ensuring the viability of data sharing networks by setting the "rules of the road" for innovation and participation. This role should include:

- **Defining the roadmap:** Setting a clear, long-term vision for national health and social care interoperability.
- **Driving standardization:** Championing the adoption of specific, open standards like FHIR, USCDI, and Gravity Project terminologies as a condition for participation in federal programs.
- **Targeted funding:** Providing strategic funding and incentives to accelerate the adoption of these standards, particularly in under-resourced sectors like social care, behavioral health, and post-acute care.

VB-3. What are essential health IT capabilities for value-based care arrangements?

Closed-loop referral technology is an essential health IT capability. Value-based care requires providers to be accountable for outcomes that are heavily influenced by social drivers. It is not enough to simply screen for a need; providers must be able to seamlessly connect a person to a resource and, most importantly, confirm that the need was met. This "closed-loop" capability provides the data and assurance necessary for success in risk-based models.

VB-4. What are the essential data types needed for successful participation in value-based care arrangements?

Comprehensive social care data is essential. This includes not only data from SDoH screening tools, but also structured data on social care referrals (e.g., to what type of service), referral status (e.g., in progress, service rendered), and the ultimate outcome of that referral. This data provides the context needed for accurate risk stratification, proactive care management, and the ability to measure the true ROI of addressing social needs.

Sincerely,

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