June 16, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: Request for Information; Health Technology Ecosystem; CMS-0042-NC
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on Health Technology Ecosystem (CMS-0042-NC)

Dear Administrator Oz,

The American Psychiatric Association (APA) appreciates the opportunity to respond to the Request for Information on the Health Technology Ecosystem. As the leading professional organization representing psychiatrists and the field of mental health, the APA is committed to ensuring that digital health technologies enhance, rather than hinder, the delivery of high-quality, evidence-based psychiatric care. Our comments reflect the unique needs of individuals with mental health conditions and the clinical realities faced by psychiatrists across diverse practice settings. We emphasize the importance of rigorous clinical evaluation of digital health tools, particularly patient-facing applications, to ensure their safety, effectiveness, and usability for individuals with varying levels of technological access and capabilities. We also highlight the critical need to address privacy concerns, avoid exacerbating clinician burden, and ensure that health IT seamlessly coordinates—not fragments—psychiatric services. Our detailed feedback aims to support policies that promote equitable, person-centered, and clinically grounded technology integration.

Digital Health Apps

PR-1. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved digital health products for their patients?

FDA approval is essential for patient-facing digital health products. However, more rigorously designed randomized trials will need to be required to make a substantial difference in patient outcomes and quality of life. The second aspect, which would also be able to be determined through large rigorously designed randomized trials, is patient engagement with the app over time. This requires that the apps are designed with an eye towards usability and impact on patient-centered goals. If clinical trials show that drop-out rates are considerable, then it may not be appropriate to recommend their use. Clinical trials also need to assess whether individuals are

dropping out due to symptom worsening or other harms of the apps in addition to the engagement style or other technological features of the app. For more severely ill patients, use of a digital app when a more robust treatment is required could lead to delays in accessing effective treatments and this information would be essential to know before discussing the addition of digital apps with patients. As with any clinical interventions, clinicians have an obligation to discuss the likely benefits and harms of the intervention as compared to other possible treatments for the patient's condition. Treatment costs may also affect patients' ability to use digital products, and they may need access to the appropriate technology to use the app, including appropriate bandwidth or internet access. While some individuals who are receiving Medicare are skilled users of technology, others may have difficulties using technology due to cognitive limitations, issues with vision or hearing, or other factors. These elements would also need to be considered in discussing digital products with patients. Privacy considerations are also crucial when considering digital health products, as they could involve the handling of sensitive personal and medical data and play a vital role in maintaining patient trust and ensuring ethical standards in digital care delivery. Development of standards for privacy and security can help providers leverage digital health products.

PR-2. What are the obstacles to developing, deploying, or effectively using digital applications for physician workflows (e.g., quality reporting, clinical documentation, billing)? How could these obstacles be mitigated?

As healthcare continues to embrace digital transformation, mobile applications integrated with electronic health record (EHR) systems are playing an increasingly prominent role in clinical workflows. Digital apps that are associated with EHR software can allow quick review of results outside of the office or during ground rounds. They may also facilitate dictation, and more recently ambient AI technology can facilitate it. In general, factors such as billing and quality measure reporting are best done within the normal workflow, and, for the majority of clinical tasks, a laptop or desktop is preferable to use with a keyboard and larger screen size. If digital apps help physicians in their daily responsibilities, no incentives will be needed, and they will adopt these applications on their own. If digital apps add to burdens and fragmentation of workflow, it will add to burnout making adoption limited.

PR-3. How important is it that all data in an EHR system be accessible for exchange, regardless of format?

Greater availability of data that is not clinically relevant is not necessarily helpful and can potentially contribute to provider burnout. Data should be imported as discrete data elements that permit easy trending of lab results, vital signs, or other key data over time. Data that is imported in scanned documents or pdf files, is unlikely to be accessed or incorporated in a consistent fashion.

While broad data accessibility in electronic health records (EHRs) is a key goal, not all information holds equal clinical value. Requiring the exchange of all data—regardless of relevance or format—can inadvertently burden clinicians, increase cognitive overload, and contribute to provider burnout without improving patient outcomes. To support high-quality care and efficient clinical workflows, data exchange

should prioritize structured, discrete data elements that enable easy interpretation and longitudinal analysis—such as lab results, vital signs, and current medications. In contrast, unstructured data (e.g., scanned documents or PDFs) is often difficult to search, interpret, or integrate into clinical decision-making.

Much of the content in patient charts—such as appointment requests, phone messages, or insurance documentation— has limited clinical relevance and minimal value in cross-organizational data sharing. Mandating routine exchange of such information may impose unnecessary technical and administrative burdens. Policymaking efforts should instead focus on high-value data exchange, such as timely access to recent progress notes and care plans, improved integration of prescription monitoring programs, and ensuring data is presented in formats that support clinical efficiency and patient safety. Finally, older documentation and routine inpatient assessments often have limited utility in ongoing care. Policies should encourage data exchange standards that emphasize clinical relevance, usability, and reduction of unnecessary noise in EHR systems.

As more and more information is routinely shared, privacy issues are more likely to be a concern. Just as importantly, few EHR systems are able to discreetly label confidential information in an interoperable fashion. Privacy and security must remain paramount for patients with mental health and substance use disorders, otherwise we risk fewer people trusting care. However, if total interoperability were required, individual choice would no longer be possible to any extent. **Privacy protections must remain the highest priority for those seeking treatment for mental health and substance use disorders.**

Excessive transfer of information among providers and health facilities is costly to configure but also may detract from clinical decision making rather than facilitating it. At least in current EHR systems, significant information is still buried in free text documents, and there are few ways to synthesize information in a coherent and readable format for review. Future AI systems may be able to synthesize information in a more usable fashion, however until that can occur having excessive information available may distract clinicians from reviewing and incorporating the more relevant information.

PR-4. What policy or standards changes might allow third-party apps to access workflows like intake forms, provider schedules, and appointment settings?

Although many institutions are beginning to allow some electronic scheduling of appointments by patients via third party applications, there are also challenges with such approaches. Widespread access to provider schedules and appointment settings is likely to be associated with a multiplicity of workflow problems. Depending on the intake process, intake questions may include complex logic (e.g., asking one set of questions if a question is answered in the affirmative but another set of questions in response to other answers) or question options (e.g., multi-select, comments). Although many practices or institutions will use a third-party solution to facilitate intake or scheduling, requiring that a multiplicity of third-party apps be able to access these features would present security risks as well as add significant cost for organizations.

Information Blocking

PR-12. Should ASTP/ONC revise information blocking exceptions to improve electronic health information exchange and market competition?

APA recommends maintaining the current state of information blocking regulations. Every change is associated with major burdens for organizations. The biggest source of information that is useful for providers is insurer claims data. For example, New York State has put together a web-based tool with information based on Medicaid claims data that is actually very helpful from a clinical standpoint. APA would recommend a similar approach to create a tool for insurers, including CMS to improve sharing of electronic health information.

The American Psychiatric Association appreciates the opportunity to provide feedback on the evolving health technology ecosystem. As the nation's leading psychiatric organization, we are committed to ensuring that health IT systems equitably support mental health and substance use care, protect patient privacy, and reduce burdens on clinicians. We welcome continued collaboration with CMS and related agencies to ensure that digital innovation enhances—rather than hinders—the delivery of high-quality, person-centered psychiatric care. Please do not hesitate to reach out for further clarification or discussion on any of our comments by contacting Zuhal Haidari (zhaidari@psych.org), Director of Digital Health.

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