January 4, 2021

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications [CMS-9123-P]

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am sharing our comments on the Centers for Medicare and Medicaid Services' (CMS) *Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information* proposed rule. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

While ACP appreciates CMS' ongoing Patients over Paperwork initiative and efforts to reduce administrative and regulatory burden, we are very disappointed that the Agency only allowed for a 25-day comment period for industry stakeholders to provide feedback on important burden reduction proposals. The requirements and specifications outlined in the proposed rule are highly technical and warrant thoughtful feedback from the community who will be implementing and abiding by these new requirements. **The College signed onto several**

requests[1,2] for CMS to extend the comment period and maintains that CMS should have allowed for a 60-day review and comment window. In addition to the technical proposals within the notice of proposed rulemaking (NPRM), there are numerous requests for information (RFIs) spanning topics around methods for patient and physician control of health data, exchanging behavioral health data, use of standards related to social risk data, and more. These RFIs cover important and complex topics that deserve thorough responses to help inform future policy development. **Therefore, if CMS does not extend the comment period, ACP recommends the Agency re-publish the RFIs at a later date with at least an additional 30-day comment period to allow for comprehensive feedback from all necessary stakeholders.**

ACP believes health information technology (IT) can and should be an integral tool in facilitating burden reduction, including sharing useful and meaningful electronic health information and streamlining the prior authorization (PA) process. **The adoption and consistent implementation of standards will help reduce variability across electronic health records (EHRs) and health IT systems – and ACP commends CMS for beginning to move the policy needle in this direction.** However, to ensure the functionality meets the necessary requirements and does not end up decreasing EHR usability and increasing physician burden, the technical fixes need to be implemented with great consideration and coincide with other non-technical changes including all payers' (public and private) willingness to harmonize their various requirements, among many other factors. Addressing the underlying factors stemming from our multifaceted health care system along with improving the technology will help to better reduce complexity and unnecessary administrative and regulatory burden. Filling out a different form for each payer interaction, even if one is able to search for the payer's specific requirements within a database, is still burdensome regardless of the type of technologies used. Physicians and patients need to have the process automated so there is little to no additional effort on their part to complete the administrative process. Therefore, ACP offers the following priority comments and recommendations:

- **Along with the Fast Healthcare Interoperability Resources (FHIR) standards and associated implementation guides (IGs) proposed within this proposed rule, ACP urges CMS to collaborate with private payers, the Office of the National Coordinator for Health IT (ONC), health IT vendors, physician organizations, third-party app developers, and other necessary stakeholders to establish a standardized set of data elements and report formats for PA requests so that health IT can be programmed to generate and send this data automatically. This agreement and process should be done in a transparent manner and include input from all necessary stakeholders.**
- **CMS must include Medicare Advantage (MA) plans in all efforts to streamline PA processes. Much of the existing burden related to PA processes stems from the varied requirements established by private payers, including those administering MA plans. There will be little to no burden reduction if these payers are excluded.**

[1] Joint Letter Requesting Extension of Comment Period for CMS Reducing Physician and Patient Burden Proposed Regulation

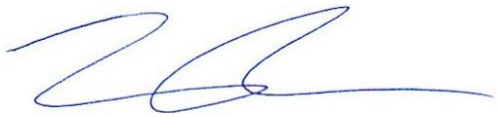
[2] eHI Joint Letter Requesting Extension of Comment Period for CMS Reducing Physician Burden and Prior Authorization Proposed Regulation

- **CMS should expand the types of PAs in scope for these proposed requirements to include prescription drugs and/or covered outpatient drugs. Limiting the types of PA to "items and services," in addition to excluding MA plans, will significantly restrict the amount of burden reduction across the health care system.**

In addition to the above discussion and recommendations, the following Summary and Comment Table contains ACP's detailed comments and recommendations on the provisions within the NPRM. ACP has chosen not to respond to the RFIs given the extremely short comment period and strongly recommends CMS re-issue these important RFIs to allow necessary stakeholders to thoroughly review and provide the comprehensive feedback necessary for thoughtful and evidence-based policy development.

Thank you for considering our comments on this important set of burden reduction policies. Please contact Brooke Rockwern, MPH, Senior Associate, Health IT Policy at brockwern@acponline.org if you have any questions or need additional information.

Sincerely,



Zeshan A. Rajput, MD, MS
Chair, Medical Informatics Committee
American College of Physicians

Summary and Comment Table

Summary of CMS Proposals	ACP Comments
Purpose of Notice of Proposed Rule Making (NPRM): CMS states the proposed provisions aim to reduce payer, physician, and patient burden by enhancing certain policies from the "CMS Interoperability and Patient Access Final Rule," improving the electronic exchange of health care data, and streamlining processes related to prior authorization (PA). This NPRM includes proposals for implementation specifications (or implementation guides) for adoption by HHS as part of a nationwide health information technology infrastructure that supports reducing burden and health care costs and improving patient care. By ONC proposing these implementation specifications in this way, CMS and ONC are together working to ensure a unified approach to advancing standards in HHS that adopts all interoperability standards in a consistent manner, in one location, for HHS use.	ACP supports the intent to provide more specific guidance to those implementing FHIR-based standards to improve the exchange of electronic information across health IT systems. **The College agrees that the adoption and consistent implementation of standards will help reduce variability across EHRs and health IT systems – and ACP commends CMS for beginning to move the policy needle in this direction.** However, to ensure the functionality meets the necessary requirements and does not end up decreasing EHR usability and increasing physician burden, the technical fixes need to be implemented with great consideration and coincide with other non-technical changes including all payers' (public and private) willingness to harmonize their various requirements, among many other factors. Building technology is necessary but not sufficient. Policies that encourage the desired behaviors are also necessary. **Addressing the underlying factors stemming from our multifaceted health care system along with improving the technology will help to better reduce complexity and unnecessary administrative and regulatory burden.** Filling out a different form for each payer interaction, even if one is able to search for the payer's specific requirements within a database, is still burdensome regardless of the type of technologies used. Physicians and patients need to have the process automated so there is little to no additional effort on their part to complete the administrative process.
Regulated Entities: The proposed rule is placing new requirements on state Medicaid and Children's Health Insurance Program (CHIP) Fee-For-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans on the Federally-facilitated Exchanges. While they are not including Medicare Advantage (MA) plans (i.e., Medicare Part C), CMS notes that this does not preclude MA plans and other payers from implementing the PA policies.	Since CMS did not include MA plans as part of the regulated entities, ACP is concerned that the proposals will not result in any noticeable burden reduction due to the fact that the majority of PA burden stems from the varying and opaque requirements established by private payer MA plans. While CMS notes this does not preclude other plans from participating, we are not confident that other payers would implement these polices. **ACP recommends CMS extend the regulated entities to include MA plans.**
Types of Prior Authorizations Included: CMS proposes limiting the PA provisions to PA for "items and services" – therefore, the NPRM does not incorporate proposals for streamlining PA for prescription drugs and/or covered outpatient drugs.	Efforts to streamline PA for health care items and services is a step in the right direction but unfortunately will not go far enough to reduce burdens of PA. Excluding prescription drugs and/or outpatient drugs, in addition to not requiring MA plans to implement these same PA proposals, will

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	significantly limit the amount of actual PA burden reduction across the health care system. **ACP recommends CMS include PA processes for prescription drugs and/or outpatient drugs within the scope of the final rule.**
Patient Access API: CMS discusses requirements for the Patient Access application programming interface (API) including allowing patients to easily access their claims and encounter information, and a specified sub-set of their clinical information as defined in the US Core for Data Interoperability (USCDI) version 1 data set through third-party applications of their choice. CMS proposes that impacted payers make data available no later than one business day after a claim is adjudicated or encounter data are received (dating back to January 1, 2016). CMS is proposing the use of specific Implementation Guides (IG) and that payers include information about pending and active PA decisions. If finalized, beginning January 1, 2023, impacted payers would be required to ensure their APIs are conformant with these IGs. If finalized, impacted payers would be permitted to use an updated version of any or all IGs proposed for adoption in this rule if use of the updated IG does not disrupt an end user's ability to access the data through any of the specified APIs discussed. This proposal amends the process finalized in the "CMS Interoperability and Patient Access" final rule to allow payers to use new standards as they are available as well as the proposed IGs. In addition, CMS proposes to require that impacted payers establish, implement, and maintain a process to facilitate requesting an attestation from a third-party app developer requesting to retrieve data via the Patient Access API that indicates the app adheres to certain privacy provisions. They also propose requiring impacted payers to report (quarterly) certain metrics about patient data requests via the Patient Access API quarterly to CMS. • The total number of unique patients whose data are transferred via the Patient Access API to a patient designated third-party app; and • The number of unique patients whose data are transferred via the Patient Access API to a	ACP is supportive of efforts to place pertinent health information directly in the hands of patients and make it more easily accessible. Doing so offers the opportunity to enhance patient-physician collaboration, empower patients to participate in health care decision-making and the self-management of their well-being, and result in more safe, efficient, and effective care being provided. ACP also supports the intent to provide more specific guidance to those implementing FHIR-based standards to improve the exchange of electronic information across health IT systems. **The College agrees that the adoption and consistent implementation of standards will help reduce variability across EHRs and health IT systems – and ACP commends CMS for beginning to move the policy needle in this direction.** However, as discussed previously, limiting the scope of impacted payers and types of PA processes, does not go far enough to significantly decrease the burden associated with PA. ACP does not support allowing impacted payers to implement new versions of IGs without clear and public advance notification and planned schedule for rollout, including providing the ability for API users to test the new version in advance. **ACP recommends CMS state an intention to specify the current versions of IGs at a later date (e.g., July 1, 2022) rather than specifying the current version numbers in the final rule. Additionally, the College recommends CMS stand up a taskforce, similar to ONC's FHIR at Scale Taskforce (FAST) to coordinate the rapid advancement of the specified IGs.** As the payer claims-based data are made available to patients via APIs, the College has concerns with data quality issues within the claims data that may contradict the clinical information maintained by the patient's physician and other health care professionals. Moreover, the claims data itself may be difficult for patients to interpret and understand. The College is concerned that the responsibility to examine and correct such data—potentially out of context, which is problematic in and of itself—could fall to a patient's primary care physician, adding to existing administrative burden that is increasingly interfering with the patient-physician relationship. **In making such data available directly to patients, CMS must**

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patient designated third-party app more than once. CMS notes that although Medicare FFS is not directly impacted by this rule, the Agency is targeting to implement the same provisions within Medicare FFS, if finalized. In this way, the Medicare FFS implementation would conform to the same requirements that apply to the impacted payers under this rulemaking, so that Medicare FFS beneficiaries would also benefit from the proposed data sharing and PA provisions.	**make it clear that it is the duty of payers to correct and update any inaccurate information and should require a mechanism that allows for patients' concerns regarding inaccurate information to be addressed.** ACP commends CMS for proposing requirements for impacted payers to maintain a process for third-party app developers retrieving patient data to attest to adhering to certain privacy provisions. Personal health information is some of the most sensitive and private information for an individual. ACP appreciates CMS' attempts to address the gap in federal privacy regulations for non-HIPAA covered entities (including many third-party apps). **Promoting the necessary privacy and security controls for third-party apps is critical to maintaining trust within the patient-physician relationship and ACP urges CMS to work with Congress to address these issues through federal privacy legislation.** We also support requirements for impacted payers to report metrics regarding patient data requests – these data will help the industry better understand how patients are utilizing third-party apps to gain access to claims data. The College requests further clarification on CMS' intent to implement the same provisions within the Medicare FFS program. Specifically, will these provisions go through additional rulemaking for public comment, and will CMS consider the feedback received within this rulemaking cycle when it implements requirements within the Medicare FFS program?
"Provider" Directory API: CMS requires certain payers to implement and maintain a "Provider" Directory API that makes clinician directory information publicly available to third-party applications. In this proposed rule, CMS extends that requirement to state Medicaid and CHIP programs, and is requiring the use of a specific IG for the "Provider" Directory API.	Ensuring digital health contact information is updated and published is important for achieving interoperability and improving care coordination. ACP supports CMS' proposals to expand this requirement to the impacted payers in this NPRM. We reiterate previous comments for physician engagement in the National Plan and Provider Enumeration System (NPPES) is not overly burdensome or complex.
Payer-to-Payer Data Exchange API: CMS requires certain payers, with the approval and at the direction of a patient, to exchange specified clinical data (specifically the USCDI version 1 data set). CMS proposes to extend that provision to state Medicaid and CHIP FFS programs and require the use of FHIR-based API and Hl7 FHIR version 4.0.1 IG and HL7 FHIR Bulk Data Access (Flat FHIR) specification to support exchanging adjudicated claims and encounter data (not	The College supports the intent of CMS' proposal in facilitating the continuity of patient health information even when they switch payers. As noted earlier, ACP supports the intent to provide more specific guidance to those implementing FHIR-based standards to improve the exchange of electronic information across health IT systems. We have concerns that since the receiving payer is not required to consult the information regarding pending and active PAs, that they simply will not do so. Additionally,

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including cost information), clinical data as defined in the USCDI, and information related to pending and active prior authorization decisions. CMS does not propose that the receiving payer be required to consult the information but suggests that consulting the information could reduce burden for all parties. Further, they request comments for future rulemaking concerning requiring that payers demonstrate that the information has been reviewed and considered. CMS does propose to require that the incoming information become part of the patient's cumulative record. CMS proposes to require the Payer-to-Payer API be conformant with the PCDE IG instead of the PDex IG when sharing this information, as this IG addresses data sharing between payers more specifically. PDex would be better suited for an exchange from a payer to patients and providers. Given the shared FHIR resources across the two IGs, CMS does not believe requiring the use of both IGs – one for each appropriate recipient of the data – adds significant burden to payers. CMS also proposes that this required Payer-to-Payer API must be able to share the specified data conformant with the HL7 FHIR Bulk Data Access (Flat FHIR) specification.	we could support this information becoming part of the patient's cumulative record if it is implemented, exchanged, and displayed in a useful and understandable format. In previous rulemaking cycles, ACP has expressed support for CMS' efforts to utilize the USCDI v1 data elements in the exchange of information between payers. We would like to reiterate our support while also highlighting the concerns around payers instituting contractually mandated access to clinicians' EHRs as a condition for clinician participation in a plan. This could negatively affect small, independent, and rural practices that are unable to afford EHRs that payers determine share adequate clinical information with them. Moreover, we have also expressed concerns about payer's increased access to clinical information impacting coverage decision-making. While historically physicians have controlled the patient's clinical data in determining what to submit to obtain reimbursement for care provided, payers would now have access to information outside of the scope of the specific service being billed. It's possible that payers could impose barriers or restrictions on coverage for medically necessary care that a patient may have received previously. **ACP strongly contends that payer access to patient clinical data should not disadvantage beneficiaries in any way and should never be a determining factor for coverage. CMS should require payers attest that USCDI information exchanged between payers cannot be used to limit access to care in any manner.**
"Provider" Access API: CMS proposes impacted payers implement and maintain a "Provider" Access API that, consistent with the APIs finalized in the "CMS Interoperability and Patient Access" final rule (85 FR 25510), utilizes HL7 FHIR version 4.0.1 to facilitate the exchange of current patient data from payers to physicians, including adjudicated claims and encounter data (not including cost information), clinical data as defined in the USCDI, and information related to pending and active prior authorization decisions. CMS proposes impacted payers implement a standards-based Provider Access API that makes patient data available to physicians both on an individual patient basis and for one or more patients at once using a bulk specification – and supply data with a date of service on or after Jan 1, 2016. CMS proposes that all physicians	As noted earlier, ACP supports the intent to provide more specific guidance to those implementing FHIR-based standards to improve the exchange of electronic information across health IT systems. ACP has concerns about adding more complexity into the identification and attribution process when allowing each payer to design its own system for managing these workflows. Additionally, **ACP is concerned with proposals for patients to be required to opt-in to the Provider Access API for data sharing. This is inconsistent with existing HIPAA rules and if not aligned, could cause additional burden when attempting to exchange data.** Moreover, existing state laws may further hinder the ability for physicians to benefit from this API. For example, New York requires patient consent before physicians can receive information from payers.

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should have access to a payer's API to seek data on their patients even if the physician does not have any sort of relationship with that payer. CMS also seeks public comment on the benefits of having the "Provider" Access API available with and without the use of the HL7 FHIR Bulk Data Access (Flat FHIR) specification. CMS notes that the payers impacted by this proposed rule have a variety of physician relationships to consider. CMS proposes that each payer establish, implement, and maintain for itself, a process to facilitate generating each physicians current patient roster to enable this proposed payer-to-physician data sharing via the Provider Access API.	ACP supports proposals for payers to make educational resources available to physicians describing how a physician can request patient data using the payer's Provider Access APIs in nontechnical, simple, and easy-to-understand language.
Documentation Requirement Lookup Service (DRLS) API: CMS proposes all impacted payers must implement and maintain a FHIR-based DRLS API, conformant with specific IGs, and populated with their list of covered items and services (excluding prescription drugs and/or covered outpatient drugs) for which PA is required, and with the organization's documentation requirements for submitting a PA request, including a description of the required documentation.	ACP appreciates the time and effort CMS has put into developing the DRLS API with industry partners. The ability to find payers' lists of covered items and services that require PA as well as the associated documentation requirements is one aspect of improving transparency around varying payer requirements. However, this technical proposal is an example of where this functionality may end up decreasing EHR usability and increasing physician burden. Filling out a different form for each payer interaction, even if one is able to search for the payer's specific requirements within a database, is still burdensome regardless of the type of technologies used. Physicians and patients need to have the process automated so there is little to no additional effort on their part to complete the administrative process. **While we support CMS' proposals for the adoption and consistent implementation of standards , ACP urges CMS to collaborate with private payers, ONC, health IT vendors, physician organizations, third-party app developers, and other necessary stakeholders to establish a standardized set of data elements and report formats for PA requests so that health IT can be programmed to generate and send this data automatically. This agreement and process should be done in a transparent manner and include input from all necessary stakeholders.**
Prior Authorization Support (PAS) API: In this proposed rule, CMS is requiring impacted payers to implement and maintain a FHIR-based Prior Authorization Support (PAS) API – with the capability to access and send prior authorization requests and decisions, integrate these notifications within existing workflow, while maintaining alignment with HIPAA transaction standards. CMS proposes that impacted payers must transmit, through the proposed PAS API,	ACP supports the intent of the PAS API proposal as the concept of providing PA information to all necessary parties would be helpful. However, as noted previously, there is still a considerable amount of work to be done for these API's to truly streamline the process. **All stakeholders, including payers, physicians, and third-party app developers, need to engage in the development of these technologies to ensure they are actually streamlining the PA process and reducing burden across the health care**

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information regarding whether the payer approves (and for how long), denies, or requests more information related to the PA request. Additionally, it is proposed that payers must include a specific reason for denial with all PA decisions, regardless of the method used to send the PA decision.	**ecosystem.** It is also necessary to assess whether these proposals properly align with the recent updates to HIPAA that are going through public review and comment. **The PAS API should be tested and piloted to help determine if it truly decreases burden. These pilots could include non-technical policy proposals incentivizing adoption of APIs.** For example, payers could guarantee that physician claims would be paid if the physician uses the specific PAS API.
Prior Authorization Response Times: CMS proposes that all impacted payers, excluding the QHPs on the FFE, will be required to respond to PA requests as expeditiously as a beneficiary's health condition requires and under any circumstances no later than 72 hours of receiving a request for expedited decisions. Notice should be provided no later than 7 calendar days after receiving a request for standard decisions. For Medicaid managed care plans, CMS proposes to maintain that an extension of 14 days is authorized if the enrollee requests it or a health plan determines additional information is needed. Additionally, CMS requires impacted payers to publicly report certain metrics about PA processes for transparency including: • A list of all items and services that require prior authorization; • The percentage of standard prior authorization requests that were approved, reported separately for items and services; • The percentage of standard prior authorization requests that were denied, reported separately for items and services; • The percentage of standard prior authorization requests that were approved after appeal, reported separately for items and services; • The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, reported separately for items and services; • The percentage of expedited prior authorization requests that were approved, reported separately for items and services; • The average and median time that elapsed between the submission of a request and a decision by the payer, plan or issuer, for standard prior authorizations, reported separately for items and services.	ACP supports requiring timeframes for payers to respond to PA requests; however, we believe the proposed timeframes offer impacted payers too much time to respond and could result in significant delays in patient care. Moreover, since this does not include MA plans, there remains a significant gap in requirements for PA responses from payers. **We reiterate previous comments that MA plans and PAs for prescription drugs must be included in these proposals for any meaningful burden reduction to occur.** The College also supports CMS' proposals requiring impacted payers to publicly report certain metrics about their PA processes in an effort to promote transparency. Providing this information could have benefits in demonstrating overly restrictive PA processes by payers or showing when PA is almost always approved and therefore only in place to delay approval and appropriate care for patients.

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Request for Comments on Improving PA - "Gold-Carding" Programs for Prior Authorization CMS encourages payers to adopt gold-carding methods for PA • Seeking comment for consideration for future rulemaking on how best to measure whether and how these types of approaches and programs actually reduce provider and payer burden. • Seek comment for potential future rulemaking on the incorporation of gold-carding into star ratings for QHP issuers on the FFEs. We also considered proposing gold-carding as a requirement in payer's prior authorization policies and seek comment on how such programs could be structured to meet such a potential requirement.	ACP supports efforts like "Gold-Carding" programs for PA but recommends CMS implement procedures for reviewing these programs to ensure that physicians are not persuaded from ordering certain tests or medications to maintain their gold-cared status with any given payer.
Request for Comment on Improving PA – Restrictions for Repeat PA for Chronic Condition (macular degeneration injection example) • Seek comment on whether there should be certain restrictions regarding requirements for repeat prior authorizations for items and services for chronic conditions, or whether there can be approvals for long term authorizations. • What alternative programs are in place or could be considered to provide long-term authorizations for terminal or chronic conditions?	ACP believes restricting repeat PA for certain chronic conditions would be a reasonable policy change to reduce burden of PA – and that most PA's should be ongoing by default except for the small proportion of medications or services that should still be subject to certain re-authorization including extremely expensive medications and controlled substances.
Request for Comment on Improving PA – Losing access to approved services after changing health plans • Seek comments on whether a prior authorization decision should follow a patient when they change from one qualified health plan on the Exchange to another, or to another health plan impacted by this proposed rule, and under what circumstances that prior authorization could follow a patient from payer to payer. • Seek comment for potential future rulemaking on other prior authorization topics, such as whether prior authorizations should be valid and accepted for a specified amount of time. • CMS is interested in comments on who should determine how long an existing approved prior authorization from a previous payer should last and whether prior authorization should be	ACP would be supportive of future policy changes enabling PA approvals to follow a patient when they change health plans.

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regulated by amount of time and/or by condition.	
Request for Comment on Improving PA – standard data elements for PA An additional topic from listening sessions was the issue of the number of different forms used by payers for prior authorization requests, each with different information requirements (data elements) and methods for submission. The lack of standard forms and requirements from payers is considered burdensome and time consuming for both patients and providers. • CMS requests input on solutions to standardizing prior authorization forms, including the possibility of developing an HL7 FHIR based questionnaire for prior authorization requests. • Input on requiring the use of a standardized questionnaire could inform future rulemaking.	ACP supports reducing the variability in payer PA form use and using the FHIR-based Questionnaire standard would help reduce that variability to some degree. However, we have concerns that payers will maintain variability in the questions asked within the questionnaire and thus not address the underlying burden of the PA process. **Therefore, ACP continues to urge CMS to collaborate with private payers, ONC, health IT vendors, physician organizations, third-party app developers, and other necessary stakeholders to establish a standardized set of data elements and report formats for PA requests so that health IT can be programmed to generate and send this data automatically. This agreement and process should be done in a transparent manner and include input from all necessary stakeholders so that technology, like the FHIR-based Questionnaire, could be used to automatically pull the PA documentation requirements from the data elements that already exist within the EHR.**