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Why and how healthcare providers should prepare for the Burden Reduction Act

In a world where everything seems digital, there are still delays and information gaps in communication. This is particularly true within the healthcare industry where data is king, but there always seems to be something missing.

Lawmakers have been working to create more transparency and make patient data more accessible since 2020 with the Centers for Medicare and Medicaid Services CMS Interoperability and Patient Access Final Rule (CMS-9115-F). This law was the first to require payers to use application programming interfaces (APIs) to share health data with other payers, providers and patients.

In January 2024, a new law passed, adding more information and requirements to the earlier CMS-9115-F. The new law, CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), or the Burden Reduction Act, stipulates specific APIs focused on creating more efficient data exchange processes for payer-to-payer connections, as well as payer-to-provider and patient access. The APIs are mandated to be developed and operable by January 1, 2027.

While payers are preparing to meet the regulatory requirements, providers should also be getting ready. Both CMS interoperability laws were passed to relieve the heavy administrative burden providers face, particularly with prior authorization. Within the new laws, prior authorization practices will be different, and hopefully better.

Here are five key things you need to know:

1. **The prior authorization transaction is the first between payer and provider using the Fast Healthcare Interoperability Resources® standard (FHIR®).**

   FHIR® has been used in the healthcare world since 2012, primarily for interoperability issues. Widely adopted into larger practices, the most recent version has improved API support, which makes it easier for providers to securely and effectively access and share patient data.

   The new legislation will be the first time FHIR® will be used intentionally to communicate between payer and provider in a direct data exchange. There are many planned benefits for using the new communication method; however, additional X12 transactions will still be available.

   One driver toward the new system is that X12 standards don' t support the large amount of data payers need to make prior authorization decisions. FHIR® is more flexible, which allows the exchange of more data with ease.

2. **The federal mandate calls out CMS and CMS-related payers, but states are adding legislation to adopt the regulations.**

   The law passed at the federal level, specifically calling out CMS and related payers like State Medicaid and Children's Health Insurance Program (CHIP) agencies and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs).

   To adopt the federal requirements, states are creating their own legislation. State-led reform has been going on for years, as evidenced by bills like Washington HB1357 and SB 5346 CR-103 that stipulate what information is exchanged using FHIR®, response times and reporting requirements for standard decisions and extenuating circumstances.

   Nine states and the District of Columbia passed laws about prior authorization in 2024. For example, in Minnesota, payer organizations must provide an annual report including the data about how many prior authorizations were approved and denied during the year.

   The interest in optimizing the prior authorization process at both the federal and state levels is likely to continue following the Burden Reduction Act go-live on January 1, 2027. Implementing these new processes should be part of your practice strategy for the upcoming years.

3. **There are three primary transaction types that will be part of the new prior authorization API.**

   In the evolving landscape of healthcare interoperability, the FHIR®-based APIs for prior authorization offer advantages over traditional EDI transaction flows, enhancing efficiency, accuracy and patient care.

   Three key areas that will have the most direct impact on providers:

   a. Coverage requirements and discovery (CRD) API

      This API answers the question "Is a prior authorization required?" Prompted when an appointment is booked and the order is selected or signed, this transaction tells providers up front if prior authorization is required. Consistent data across payers hasn't previously been available to providers, which often prompts unnecessary prior authorizations and delays in care.

   b. Documentation, templates and rules (DTR) API

      This API streamlines the documentation process by providing templates and rules to providers, ensuring all necessary information is captured correctly before an authorization is submitted.

   c. Prior authorization support (PAS) API

      This API is most closely related to the prior authorization providers submit today; however, the FHIR®-based API allows for more detailed and structured data exchange. It incorporates the ability to include clinical data and documentation directly within the prior authorization request, streamlining the process and reducing the need for additional information requests that often lead to delays in authorization approval.

   The new APIs will make it easier for providers to quickly understand whether a prior authorization is required, and if so, what needs to be submitted. It will also allow for the transaction to be completed digitally with a near-real-time response about the status.

4. **Estimated prior authorization workload savings will be across physician, nurse and clerical roles.**

   Prior authorizations are notoriously time-and labor-sensitive. The new regulations will create process efficiency, particularly when it comes to understanding the requirements and how quickly payers respond. There will still be human intervention, as someone will have to manage and track the prior authorization as it goes through the process, but there will be fewer touchpoints.

   Improved transparency and communication will:

   a. Allow providers to better communicate to their patients the reason for denial and reason(s) for potential treatment plan changes

   b. Help patients better understand how decisions are made relating to access to care

   c. Decrease the number of arbitrary prior authorization denials and minimize the number of denials that are overturned on appeal

   d. Reduce unnecessary delays in patient care

   The new law may be directed at payers, but it stands to help providers take back time spent on administrative burdens and put it toward patient care.

5. **There's more information available.**

   The best place to find more information and additional resources about the new legislation is the CMS legislation page.

The Burden Reduction Act legislation will go into effect in 2027, but providers should begin planning for the changes now. A great first step would be to reach out to your electronic health record (EHR) or electronic medical record (EMR) vendor to see what plans they have in place for the upcoming regulations.

World Headquarters
300 Frank W. Burr Blvd.
Suite 36, 6th Floor
Teaneck, NJ 07666 USA
Phone: +1 201 801 0233
Fax: +1 201 801 0243
Toll Free: +1 888 937 3277

European Headquarters
280 Bishopsgate
London
EC2M 4RB
England
Tel: +44 (01) 020 7297 7600

India Operations Headquarters
5/535, Okkiam Thoraipakkam,
Old Mahabalipuram Road,
Chennai 600 096
Tel: 1-800-208-6999
Fax: +91 (01) 44 4209 6060

APAC Headquarters
1 Fusionopolis Link, Level 5
NEXUS@One-North, North Tower
Singapore 138542
Tel: +65 6812 4000

WF3513150