CMS Administrator Seema Verma recently told the American Medical Association that CMS will tackle prior authorization this year, calling the process indefensible just one day after the president’s fiscal 2021 budget proposed to add prior authorization requirements to traditional Medicare.

“The prior authorization process became indefensible years ago. Patients are frustrated and doctors are sick of pointlessly wrangling with insurance companies,” Verma told the physicians’ national advocacy conference. “Prior authorization requirements are a primary driver of physician burnout, and even more importantly, patients are experiencing needless delays in care that are negatively impacting the quality of care they receive.”

She added that while prior authorization is an important utilization management tool, CMS believes automation can make the process more efficient, and “this is a priority for us.” Verma said the administration is ready to take action.

Verma’s remarks came one day after the president unveiled multiple prior authorization proposals in his fiscal 2021 budget, including one that “extends the narrow existing authority to all Medicare Fee-for-Service items and services,” though CMS would target the authority toward areas that are at a high risk for fraud and abuse, like inpatient rehabilitation facilities, according to the HHS budget-in-brief. The proposal is estimated to save $13.7 billion over 10 years and cut down on Medicare improper payments.

“Prior authorization can be an effective tool for healthcare payers to support payment accuracy and reduce unnecessary utilization, but current law allows Medicare to use this tool on only a few fee-for-service items and services,” the budget-in-brief says.

The budget also includes proposals to require prior authorization starting in 2022 when physicians order certain services excessively compared to their peers. In particular, the proposal would set up prior authorization for those with high prescribing rates of radiation therapy, therapy services, advanced imaging, and anatomic pathology services. CMS would reevaluate which providers would be subject to the prior authorization requirements on an annual basis.

“When implementing this proposal, CMS will consider patient access and other quality concerns, in an effort to reduce patient burden while ensuring appropriate provisions of healthcare,” the budget-in-brief says.