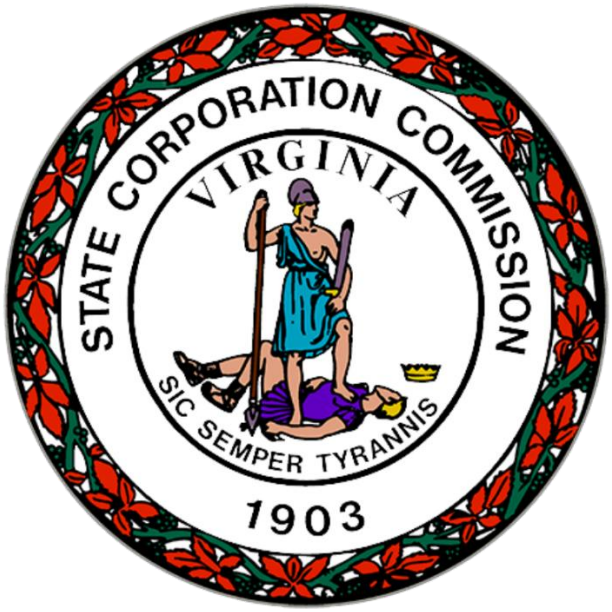
Report of the Electronic Prior Authorization Work Group

Submitted to the Chairs of the Senate Committees on Commerce and Labor and Education and Health; and Chairs of the House Committees on Labor and Commerce and Health and Human Services, pursuant to Chapter 284 of the 2025 Acts of Assembly



State Corporation Commission
Bureau of Insurance

November 1, 2025

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
COMMISSIONERS
JEHMAL T. HUDSON • SAMUEL T. TOWELL • KELSEY A. BAGOT

November 1, 2025

TRANSMITTED VIA EMAIL

The Honorable R. Creigh Deeds
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Jeion A. Ward
Chair, Labor and Commerce Committee
Virginia House of Delegates

The Honorable Ghazala F. Hashmi
Chair, Education and Health Committee
Senate of Virginia

The Honorable Mark D. Sickles
Chair, Health and Human Services Committee
Virginia House of Delegates

Dear Senator Deeds and Senator Hashmi and Delegate Ward and Delegate Sickles:

On behalf of the State Corporation Commission, in coordination with the Secretary of Health and Human Resources, the Bureau of Insurance submits this Report of the Electronic Prior Authorization Work Group on behalf of the work group, pursuant to Chapter 284 of the 2025 Acts of Assembly.

While the Bureau of Insurance and the Health and Human Resources Secretariat staffed and facilitated the work group, this consensus report represents the perspectives solely of the work group.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

Chapter 284 of the 2025 Acts of Assembly extended the term of the existing Electronic Prior Authorization (ePA) Work Group[1] from November 1, 2025, to November 1, 2028, and revised its charge to require its 2025 report to include (i) a final assessment of progress towards implementing ePA and real-time prescription benefit (RTPB) for prescription drugs pursuant to §§ 38.2-3407.15:2 and 38.2-3407.15:7 of the Code of Virginia (Code); and (ii) a recommended date by which private commercial health carriers and providers must implement medical ePA, as part of the work group's larger mandate to monitor federal developments related to its implementation, assess industry progress and readiness to implement it, and evaluate policies supporting its effective and efficient adoption.[2]

The national mandate for government plan sponsors and payers such as those under Medicare Advantage and Medicaid[3] to implement medical ePA is driving progress towards the work group's goal of ensuring that health carriers and providers ultimately operate under a unified and consistent set of technical standards and requirements across both public and private commercial markets.

Key Finding

As a follow-up to the work group's 2024 readiness survey, each statutorily named stakeholder group conducted a brief assessment of progress towards implementing prescription drug ePA and RTPB. While it is too early to know the full extent of progress, stakeholder reports were nevertheless generally positive but mixed and supported anecdotally by limited data and feedback. On the one hand, carriers and providers were encouraged by the lack of concerns expressed by their constituents. On the other hand, pharmacists had not yet experienced expected signs that the new requirements are changing provider workflows from retrospective to prospective prior authorization determinations.

Key Recommendations

The work group recommends that the date for health carriers to implement medical ePA in the private commercial health insurance market be consistent with and linked by reference to the federal requirements for Medicare Advantage and Medicaid under the 2024 Prior Authorization Rule.[4] That requirement date is currently January 1, 2027. It further recommends that legislation be proposed in the 2026 regular session of the Virginia General Assembly that would codify this date requirement and tie it to the applicable regulations, as was done in 2025 for metrics reporting. The work group also recommends that providers be required to ensure their electronic health record systems can access the ePA application programming interfaces (API) established by private commercial health carriers, but with a minimum one-year delayed effective date from the required implementation date for carriers.

The work group also recommends that it monitor and consider options for moving the prior authorization process for prescription drugs from a less retrospective to a more prospective[5] process now that ePA and RTPB systems should be in place.

1. Introduction

Chapters 284 and 285 of the 2022 Acts of Assembly accelerated the drive towards automation of the prior authorization process for prescription drugs and the provision of real-time, patient-specific benefit information to enrollees and contracted providers for covered prescription drugs in the private commercial health insurance market. This legislation required carrier contracts with providers to include provisions for the implementation of ePA and RTPB, beginning July 1, 2025,[6] provided the legislation was reenacted in the 2023 regular session of the Virginia General Assembly. It also directed the State Corporation Commission (Commission), in coordination with the Secretary of Health and Human Resources (SHHR), to establish a stakeholder work group to evaluate and make recommendations to modify the process for prior authorization for prescription drug benefits to maximize efficiency and minimize delays.

As recommended in the 2022 work group report, the General Assembly subsequently amended the ePA and RTPB requirements and reenacted the provisions of the 2022 legislation in Chapters 474 and 475 of the 2023 Acts of Assembly. These provisions were ultimately codified in §§ 38.2-3407.15:2[7] and 38.2-3407.15:7 of the Code. It also extended the term of the ePA work group through November 1, 2025, while expanding its charge to include evaluating the use of ePA for certain medical services.

The term of the existing electronic prior authorization (ePA) work group was extended in Chapter 284 of the 2025 Acts of Assembly from November 1, 2025 to November 1, 2028. The 2025 legislation also revised the work group's charge to require its November 1, 2025, report to include (i) a final assessment of progress towards implementing ePA and real-time prescription benefit (RTPB) for prescription drugs as prescribed in §§ 38.2-3407.15:2 and 38.2-3407.15:7 of the Code; and (ii) a recommended date by which private commercial health carriers and providers must implement medical ePA, as part of its larger mandate to monitor federal developments related to its implementation; assess industry progress and readiness to implement it, and evaluate policies supporting its effective and efficient adoption.

In fulfilling its statutory mandate, the work group seeks to ensure that health carriers and providers ultimately operate under a unified and consistent set of technical standards and requirements across both public and private commercial health insurance markets when processing ePA and RTPB requests. The national mandate for government plan sponsors and payers, such as those under Medicare Advantage and Medicaid, to automate prior authorization is driving progress towards this end. Consequently, as it maps out a plan for implementing ePA in the private commercial health insurance market in Virginia, the work group is closely monitoring parallel federal developments for future alignment.

The work group must submit its annual report by November 1 to the chairs of the Senate Committees on Commerce and Labor and Education and Health; and the House Committees on Labor and Commerce and Health and Human Services.[8] This is its fourth annual report. This report is submitted by the Commission on behalf of the work group whose perspectives it represents.

Statutorily named work group members include representatives of the Virginia Association of Health Plans, Medical Society of Virginia, Virginia Hospital and Healthcare Association, and the Virginia Pharmacy Association. The list of interested stakeholder organizations that participated in the work group is included in Appendix B.

Given the parallels between the ePA work group and a new work group on prior authorization metrics reporting,[9] the participating stakeholders agreed to have the two meet concurrently as one, but issue separate reports for reasons of statutory compliance, efficiency, and continuity. This work group held six meetings between April and September 2025, with a summary of each included in Appendix A.

2. Findings and Recommendations

Based on presentations, discussions, and stakeholder input, the work group makes the following findings and recommendations for 2025:

A. Assessing Progress Towards Implementation of Prescription Drug ePA/RTPB

Pursuant to subsection B of § 38.2-3407.15:2 of the Code, any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, must contain the specific provisions requiring:

- Health carriers to establish and maintain an online process that links directly to all e-prescribing systems and electronic health record systems using the National Council for Prescription Drug Programs SCRIPT Standard© and its Real-Time Prescription Benefit Standard©, and is able to accept ePA requests from a provider; and

- Participating providers to ensure that any e-prescribing or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record can access, at the point of prescribing, the ePA process established by a carrier and the patient-specific RTPB information. Providers for whom compliance with ePA provisions create an undue hardship may request a waiver from the appropriate regulatory agency within the Health and Human Resources Secretariat pursuant to subdivision B 17 of § 38.2-3407.15:2 of the Code.

Health carriers and their pharmacy benefits managers are also required in § 38.2-3407.15:7 of the Code to provide patient-specific RTPB information to enrollees and contracted providers for the office visit, including any out-of-pocket costs and more

affordable medication alternatives or prior authorization requirements, and ensure that the data is accurate.

Throughout this process, Virginia has been working to align its ePA and RTPB standards and policies with federal regulatory requirements for government plan sponsors and payers such as those under Medicare Advantage and Medicaid.[10]

Findings:

A1. As a follow-up to the work group's 2024 readiness survey, each statutorily named stakeholder group conducted a brief assessment of progress towards implementing prescription drug ePA and RTPB. While it is too early to know the full extent of progress since the new requirements have only recently taken effect, stakeholder reports were nevertheless generally positive but mixed and supported anecdotally by limited data and feedback. On the one hand, carriers and providers were encouraged by the lack of concerns expressed by their constituents. On the other hand, pharmacists had not yet experienced expected signs that the new requirements are changing provider workflows from retrospective to prospective prior authorization determinations.

A2. The statutorily named work group members identified several constraints in conducting assessments. Chief among these were the brief window of time since implementation; the limited amount of data that could be tied to the implementation of ePA and RTPB to demonstrate its impacts; and the relative lack of Virginia-specific data. This ultimately necessitated a reliance on more anecdotal information and qualitative feedback from impacted stakeholder groups.

A3. As part of its assessment, the work group also received data from health information technology vendors and intermediaries from within their client base. While much of the data is national in scope, there is some Virginia-specific data. Nevertheless, the trends are clear both nationally and in Virginia: the availability and use of ePA and RTPB is accelerating rapidly. For example:

- Epic Systems Corporation (Epic),[11] a healthcare software company, reports a continuing increase in the adoption of ePA and RTPB. Countrywide, the percentage of Epic organizations using ePA and RTPB for prescription drugs increased from about 50% in 2023, to around 65% for ePA and 71% for RTPB in 2025.[12] For Virginia health systems using Epic, the numbers are similar though a little lower for ePA and a little higher for RTPB. Also on a countrywide basis, health systems served by Epic performed approximately 16 million ePA-related transactions and 80 million RTPB-related transactions per quarter in 2023.[13] By Quarter 1 of 2025, the number of ePA-related transactions had jumped to 29 million and RTPB-related transactions to 200 million.[14] Epic did not have separate numbers for ePA-related transactions available for Virginia.

- Surescripts Systems, Inc. (Surescripts)[15] reported a 37.2% increase countrywide from 2023 to 2024 in the percentage of prior authorizations for prescription drugs

processed electronically, and a 29.4% increase countrywide for specialty medications in that same time period.[16] It found that nearly 900,000 providers used RTPB in 2024, with use by providers up 16.1% year-over-year since 2020.[17] Real time prescription benefit responses delivered to providers in 2024 stood at 788.2 million, a 23.5% increase from 2023.[18] Specific to Virginia, Surescripts reported ePA transaction volume increased 49% from 2023 to 2024, with growth of 314% from 2020 to 2024.[19] The RTPB transaction volume in Virginia increased 36% from 2023 to 2024, with growth of 265% from 2020 to 2024. [20]

- CoverMyMeds LLC (CoverMyMeds) [21] anecdotally reported an uptick in the use of RTBP tools in Virginia in the run-up to implementation from June 2023 to June 2025. Although provider RTPB requests decreased slightly from 2023 to 2024 – which CoverMyMeds attributed primarily to contractual and product development changes – the success rate for RTPB information requests sent to payers and providers increased significantly. In 2025, requests from providers rose by 36% over the previous year, with a notable improvement in successful transfers of information from payers to providers.[22] Regarding RTPB requests where the original prescription required prior authorization and the alternative did not, from 2023 to 2024, there was a 78% increase in such requests and in 2025, this figure rose by another 41% over 2024.[23] In addition, it found that in 2022, 82% of patients reported delays in accessing medications,[24] whereas in 2025, this number had dropped to 65%.[25]

A4. As of September 1, 2025, few providers had filed waiver requests for undue hardship with the appropriate regulatory authority within the Health and Human Resources Secretariat pursuant to § 38.2-3407.15:2 of the Code.

Recommendations:

A1. The work group recommends that it monitor and consider options for moving the prior authorization process for prescription drugs from a less retrospective to a more prospective process now that ePA and RTPB systems should be in place.

A2. The work group recommends that the impacted stakeholder groups continue to inform and educate their membership of the requirements of ePA and RTPB implementation for prescription drugs beyond the July 1, 2025, implementation date.

B. ePA for Medical Items and Services

On February 8, 2024, the Centers for Medicare and Medicaid Services (CMS) published its final rule on "Advancing Interoperability and Improving Prior Authorization" (CMS Rule 0057-F)[26] (2024 Prior Authorization Rule). This rule took effect on April 8, 2024. It requires impacted payers[27] to implement and maintain a specific API for ePA for medical items and services using the Health Level Seven International® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standard. Qualified Health Plans on

state-based exchanges such as Virginia's are not subject to this requirement in the 2024 Prior Authorization Rule. However, CMS "encourage(s) . . . State-based Exchanges operating their own platform . . . to consider adopting similar requirements for (Qualified Health Plans) on their Exchanges."[28] The API must be populated with a payer's list of covered items and services, able to identify documentation requirements, and able to support prior authorization requests and responses. It must be implemented by January 1, 2027. The prior authorization API is just one of four FHIR®-based APIs required by the 2024 Prior Authorization Rule. The other APIs are patient access, provider access, and payer-to-payer. Other provisions, such as performance metrics for payers and certain prior authorization policies, must be implemented by the impacted players no later than January 1, 2026.

Virginia does not currently require private commercial health plans to implement ePA for medical items or services similar to the federal requirement in the 2024 Prior Authorization Rule, as it does for prescription drugs and prior authorization metrics reporting.

1. Federal Developments

Findings:

B.1.1: On June 23, 2025, the U.S. Department of Health and Human Services joined with health plans in announcing a six-point initiative to streamline prior authorization processes across all market segments – under both public and private commercial health plans. It calls for "expand[ing] the percentage of electronic prior authorization approvals answered in real-time to at least 80% by 2027 along with the adoption of application programming interfaces across all insurance markets."[29] This broadens current CMS policies which are largely focused on such programs as Medicare Advantage and Medicaid and reinforces the work group's recommendations to unify the workflow processes and minimize fragmentation.

B.1.2. After CMS and the Assistant Secretary of Technology Policy (ASTP)/Office of the National Coordinator (ONC) adopted several major rules in 2024, federal developments in 2025 have been more modest. The most consequential is the ASTP/ONC's final rule on "Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4)."[30] published on August 4, 2025. This rule includes certain proposals from the 2024 proposed rule on "Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2)," including new and updated health information technology certification criteria for ePA, electronic prescribing, and RTPB information. This HTI-4 component in the final rule also includes several related criteria for API functionality.[31] Using health information technology modules certified to these criteria will enable health care providers to interact with the prior authorization API requirements established by CMS pursuant to its 2024 Prior Authorization Rule.[32] This new final rule took effect on October 1, 2025.

B.1.3. In its unified agenda, CMS intends to use rulemaking to expand the policies finalized in its 2024 Prior Authorization Rule to include drugs,[33] but the status of these efforts remains uncertain.[34] While drugs were excluded from the rule, CMS has stated that "nothing in this final rule prohibits broader use of the required prior authorization API by impacted payers and we encourage them to do so to the extent permitted by law."[35]

Recommendations:

B.1.1. The work group should continue to monitor federal developments related to ePA for medical items and services as Virginia aligns its medical ePA technical standards and requirements for private commercial health plans and providers with those adopted at the federal level for such programs as Medicare Advantage and Medicaid.

2. Industry Readiness

Findings:

B.2.1. Virginia's health carriers appear ready and willing to implement medical ePA in the private commercial market in Virginia concurrent with the implementation of medical ePA in the government health insurance market pursuant to the 2024 Prior Authorization Rule. The work group received input that many health plans are already moving towards a one-system solution across all lines of business. It will be easier for carriers to update their systems simultaneously and use for all product lines instead of managing multiple integrations and processes.

B.2.2. The Workgroup for Electronic Data Interchange (WEDI) conducted a survey[36] in January and February 2025 on the implementation of the 2024 Prior Authorization Rule by payers and providers. According to the results, impacted payers reported the following progress in implementing the prior authorization API requirements nearly two years out from the date required for compliance:

- 13% were between 75 to 100% complete;
- 31% were 25% complete; and
- 43% had not yet started.

The WEDI is updating these results with a follow-up survey in late 2025, with plans for another survey in 2026, to track progress in implementing the rule. Although these numbers are not specific to payers providing coverage in Virginia, the work group finds that they are likely indicative of their readiness to implement medical ePA in Virginia's private commercial market since payers writing more than 80% of private commercial health insurance coverage in Virginia appear to write coverage in at least one jurisdiction countrywide that is subject to the requirements of the 2024 Prior Authorization Rule.[37]

B.2.3. According to health carrier representatives participating in the work group, the January 1, 2027, requirement in the 2024 Prior Authorization Rule for implementing medical ePA at the federal level, gives private commercial health plans in Virginia sufficient time to implement the applicable requirements.

B.2.4. Several states are moving forward with implementation of a unified approach across both public and private commercial health insurance markets. These include California,[38]Tennessee,[39] Utah,[40] and Washington.[41]

Recommendations:

B.2.1. The work group recommends that the date for health carriers to implement medical ePA in the private commercial market be consistent with and linked by reference to the federal requirements for Medicare Advantage and Medicaid[42] under the 2024 Prior Authorization Rule. That requirement date is currently January 1, 2027.

B.2.2. The work group further recommends that legislation be proposed for the 2026 regular session of the Virginia General Assembly that would codify this date requirement and tie it to the applicable regulations, as was done in 2025 for metrics reporting.

B.2.3. The work group recommends requiring providers to ensure their electronic health record systems can access the ePA APIs established by private commercial health carriers, but with a minimum one-year delayed effective date from the date that carriers are required to implement medical ePA.

3. Policies Supporting Implementation

The work group made no findings or recommendations on policies supporting the effective and efficient adoption of ePA for medical items and services in this year's report.

4. Looking Ahead to 2026

The work group recommends legislation be proposed during the 2026 session of the Virginia General Assembly to the extent necessary to implement its recommendations. Under its current charge, it will also continue to monitor and report on any relevant federal or state developments and industry readiness and implementation of medical ePA and file annual reports of its findings and recommendations through November 1, 2028.

In addition, the Prior Authorization Metrics Reporting Work Group considered a proposal to expand the scope of prior authorization metrics reporting to include prescription drugs. While receptive to the proposal in concept, the work group ultimately decided it would be prudent to monitor federal developments in the drug space and defer further discussion until next year. It recognized the practical aspects of implementation on a

timeline consistent with medical items and services, the uncertainty around the timeline for any federal action and the form any such reporting might take, and the work group's desire to tie any state requirements to those adopted at the federal level. Since that work group's mandate expires with the submission of its report on November 1, 2025, it recommended that such further consideration occur as part of the deliberations of the ePA Work Group and be reflected in revisions to its charge in Chapter 284 of the 2025 Virginia Acts of Assembly.

Appendix A. Summary of 2025 Work Group Meetings

The work group met six times between April and September during the 2025 reporting period.

April 22

The ePA Work Group held its initial meeting under its newly constituted charge. The work group opened with remarks from Delegate Hyland "Buddy" Fowler, Jr., patron of the 2025 legislation, to set the stage for continuing its work. Given the similarity in leadership, membership and charge between the existing ePA Work Group and the new Prior Authorization Metrics Reporting Work Group created pursuant to the third enactment clause of Chapters 58 and 68 of the 2025 Acts of Assembly, the ePA work group agreed to hold the meetings of both work groups concurrently, but issue separate reports for purposes of statutory compliance, efficiency, and continuity. The ePA Work Group reviewed its updated charge and agreed to its 2025 meeting schedule. It also discussed any needed updates to its stakeholder list and received suggestions for future presenters.

Substantively, the work group discussed efforts by impacted stakeholders to raise awareness of prescription drug ePA and RTPB implementation (a 2024 ePA work group recommendation), recognizing each group to provide updates on activities, suggested mechanisms, and timeframes for completing its final assignment related to prescription drugs. Concerns were expressed that the time available for making the assessment post-July 1, 2025, was limited and challenging. This item was continued to a subsequent meeting.

Finally, the work group discussed possible mechanisms and timeframes for assessing industry readiness to implement medical ePA. It was felt the readiness assessment for medical ePA could help inform the work group when considering a date for implementing medical ePA as required in its new charge. The work group thought that the results in the recently released survey conducted by WEDI, and the Virginia Medicaid program's implementation experience to date with the 2024 Prior Authorization Rule would be helpful.

May 21

The work group continued to discuss ways it might assess payer and provider progress towards implementing prescription drug ePA and RTPB in Virginia's private commercial market so soon after the new requirements take effect. These included using indices such as health information technology vendor data and actions by payers and providers. It was acknowledged that the assessment would be limited since the requirement would have just taken effect in July and likely be qualitative and anecdotal rather than quantitative. Each of the impacted stakeholder groups agreed to provide a full status report at the June meeting.

The work group also received a presentation from the Virginia Medicaid program office on the status of its medical ePA implementation experience pursuant to the 2024 Prior Authorization Rule since the Medicaid fee-for-service plan and managed care organizations are subject to the provisions of that rule. The work group discussed concerns over implementation by non-traditional providers, although there was some uncertainty about which provider types are considered non-traditional.

June 23

The work group received three presentations on medical ePA. The first, from WEDI, reviewed key results and insights from its survey on the implementation of the 2024 Prior Authorization Rule, including those most directly related to medical ePA. The second, from CMS, provided an update on federal developments related to medical ePA since adoption of its prior authorization rule in 2024, and any pending proposals. To establish a common base of knowledge for the work group, Leavitt Partners then reviewed the prior authorization architecture in the 2024 Prior Authorization Rule and the interplay among the four APIs from a prior authorization perspective. It updated the work group on the continuing work of HL7® to advance the implementation of medical ePA and the FHIR®-based standard through the Da Vinci accelerator project that is central to implementing ePA for medical items and services. It also covered state-driven engagements such as One Utah Health Collaborative as a possible model for Virginia and industry progress in responding to the implementation of the 2024 Prior Authorization Rule.

Following these presentations, the work group discussed potential dates for implementing ePA medical in Virginia's private commercial health insurance market and factors influencing that determination. No date was agreed upon, though there was discussion around aligning the date with the January 1, 2027, federal date.

Finally, the work group agreed that the impacted stakeholder groups would present an assessment of progress towards implementation of prescription drug ePA and RTPB at its August meeting.

July 15

Impacted stakeholders such as health plans and providers shared brief updates on the status of efforts to assess progress towards implementing ePA and RTPB for prescription drugs. A representative of a health system shared his perspective on its progress and concern that some smaller groups or independent practices might not have the same level of information technology support. He also spoke to the timing for health plan implementation of medical ePA in the private commercial health insurance market, believing it best to have one process across all plan types including Medicare and Medicaid rather than a fragmented system. Representatives of a large health carrier expressed similar sentiments concerning the timing of and approach to health plan implementation of medical ePA. Finally, the work group continued its discussion of the recommended date, with health plans amenable to a January 1, 2027, date, but

generating robust discussion when proposing that providers be required to make use of the prior authorization technology. It was suggested that perhaps the work group consider a one-year delay in any provider requirement. Unresolved, the discussion was continued until the August 19 meeting.

August 19

The work group considered several findings and recommendations proposed by work group stakeholders, agreeing on a process for preparing the draft report.

September 9

The work group considered an initial draft report, consisting of the draft findings and recommendations from the August meeting, before agreeing to circulate it for a one-week review period following this meeting. There was agreement that work group staff would make any suggested non-substantive editorial revisions, before submitting it to the work group for final approval and before submitting the final report to the designated committee chairs in the General Assembly by November 1, following the standard internal review at the Commission.

Appendix B. Work Group Resources and Stakeholders

Federal Government Resources

Centers for Medicare and Medicaid Services

Virginia Government Resources

State Corporation Commission
Virginia Department of Health Professions
Virginia Department of Medical Assistance Services
Virginia Department of Health
Office of the Secretary of Health and Human Resources (Virginia)

Interested Stakeholder Organizations

America's Health Insurance Plans (AHIP)
Arthritis Foundation
CareFirst BlueCross BlueShield
CoverMyMeds
Elevance Health (Anthem)
Leavitt Partners
McKesson
Medical Society of Virginia
National Council for Prescription Drug Programs
Pharmaceutical Care Management Association
Surescripts
Virginia Association of Health Plans
Virginia Dental Association
Virginia Health Information
Virginia Hospital & Healthcare Association
Virginia Pharmacy Association
Workgroup for Electronic Data Interchange (WEDI)

End Notes

[1] The work group was originally created by Chapters 284 and 285 of the 2022 Acts of Assembly.
[2] The work group charge uses the term "medical items and services" from the Centers for Medicare and Medicaid Services' (CMS) 2024 Prior Authorization Rule rather than the term "health care services" used in § 38.2-3407.15:8. of the Code of Virginia (effective January 1, 2027). "Health care services" are defined as having the same meaning as provided in § 38.2-3407.15 of the Code except that as used in § 38.2-3407.15:8, "health care services" does not include drugs that are subject to the requirements of § 38.2-3407.15:2.
[3] In addition, the requirements of the 2024 Prior Authorization Rule also extend to the Children's Health Insurance Program managed care and fee-for-service plans, and Qualified Health Plans on the Federally Facilitated Exchanges.
[4] CMS, "Advancing Interopeability and Improving Prior Authorization (CMS-0057-F)," 89 Fed. Reg. 8758 (February 8, 2024).
[5] For this purpose, retrospective and prospective prior authorization has to do with the timing of the prior authorization for prescription drugs – that is, whether the review takes place and is completed by the prescriber or their staff before the prescription order is transmitted to the pharmacy (prospective) or after it is received at the pharmacy from the provider, submitted to the carrier for coverage and then returned to the provider for the authorization process to be completed (retrospective).
[6] The following provisions took effect on July 1, 2025: 1) carriers must implement an ePA process for prescription drugs; 2) participating health care providers must ensure that any e-prescribing or electronic health record system they own or contract for can access the carrier's ePA process and the and real-time cost information for a covered prescription drug that is made available by a carrier; and 3) carriers or their pharmacy benefits managers must provide real-time cost information to enrollees contracted providers for a covered prescription drug, including any cost-sharing and prior authorization requirements.
[7] Subdivisions 16 and 17 of subsection B of § 38.2-3407.15:2 of the Code require carrier contracts with providers to provide for the implementation of ePA and RTPB, as follows:
"16. Requires a carrier, beginning July 1, 2025, … to establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept (ePA) requests from a provider; (iii) can approve ePA requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; (iv) links directly to real-time patient out-of-pocket costs for the prescription drug, considering copayment and deductible; and (v) otherwise meets the requirements of this section" … .
17. Requires a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access, at the point of prescribing, the ePA process established by a carrier as required by subdivision 16 and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to § 38.2-3407.15:7."
[8] After enactment of the 2023 legislation creating the Virginia ePA work group, the Virginia House Committee on Commerce and Energy was renamed the Committee on Commerce and Labor, and the House Committee on Health, Welfare, and Institutions was renamed the Committee on Health and Human Services. The 2025 legislation that amended the term of the work group and its charge also updated the names of the committees in the mandate.
[9] Chapters 58 and 68, Virginia Acts of Assembly – 2025 Session.
[10] The CMS final rule, entitled "Medicare Program; Medicare Prescription Drug Benefit Program; Health Information Technology Standards and Implementation Specifications (CMS-4205-F2)" took effect on July 17, 2024, and requires Medicare Part D plan sponsors to use only the newer version of the National Council for Prescription Drug Programs' SCRIPT Standard© on or before January 1, 2028. Also, the CMS rule adopted the National Council for Prescription Drug Programs' Real-Time Prescription Benefit

Standard© as the standard for prescriber RTPB tools supported by Medicare Part D plan sponsors, beginning January 1, 2027.

[11] Email from Tim Stolldorf, Integration Engineer, Epic Systems Corporation, September 18, 2025: "Epic is a global healthcare software company that helps people get well, helps people stay well, and helps future generations be healthier. Founded in a basement in 1979 with three half-time employees, Epic is now the leading EHR software developer in the United States. Epic supports healthcare organizations in 16 countries, with more than 3,100 hospitals using Epic and over 191 million patients using Epic's MyChart patient portal to manage their care online."

[12] Email from Tim Stolldorf, Integration Engineer, Epic Systems Corporation, May 7, 2025.

[13] Id.

[14] Id.

[15] Email from Ken Whittemore, VP, Pharmacy & Regulatory Affairs, Surescripts, September 29.,2025: "Surescripts' purpose is to serve the nation through simpler, trusted health intelligence sharing, in order to increase patient safety, lower costs and ensure quality care. Surescripts brings healthcare together to inform and accelerate decisions, helping keep patient care on track. With the Surescripts Network Alliance®, the company is empowering the healthcare ecosystem with intelligence and interoperability for smarter, faster prescribing, prior authorization, treatment, care management and more."

[16] Surescripts, 2024 Annual Impact Report, p. 17.

[17] Id. at p. 13.

[18] Id. at p. 12.

[19] Email from Emelie Jensen, Director, Product Management, Surescripts LLC September 18, 2025.

[20] Id.

[21] As described on its website: "CoverMyMeds, part of McKesson Corporation, is a medication access company committed to helping people get the medicine they need to live healthier lives. Through innovation and collaboration, CoverMyMeds' solutions seamlessly connect the healthcare network to improve medication access; thereby increasing speed to therapy and reducing prescription abandonment. CoverMyMeds' network includes 75% of electronic health record systems (EHRs), 50,000+ pharmacies, 950,000 providers and most health plans and PBMs." (Website accessed on September 18, 2025).

[22] Presentation by Tracy Russell, CoverMyMeds, to the Electronic Prior Authorization Work Group, August 19, 2025.

[23] Id.

[24] CoverMyMeds, 2022 Medication Access Report, p. 6.

[25] CoverMyMeds, 2025 Medication Access Report, p. 8.

[26] CMS, "Advancing Interoperability and Improving Prior Authorization (CMS-0057-F)," 89 Fed. Reg. 8758 (February 8, 2024).

[27] Under the CMS 2024 Prior Authorization Rule, "impacted payers" include Medicare Advantage organizations; managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans under contract with a state Medicaid agency; state Medicaid agencies; every state on behalf of its Children's Health Insurance Program; and qualified health plan (QHP) issuers offering a QHP on a federally facilitated exchange.

[28] 89 Fed. Reg. 8761 (Feb. 8, 2024), https://www.federalregister.gov/d/2024-00895/page-8761.

[29] HHS announces industry pledge to reduce and simplify prior authorization (accessed July 3, 2025).

[30] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (CMS-1833-F)," 90 Fed. Reg. 36536 (August 4, 2025). HTI-4 is published as part of this FY2026 CMS Hospital Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1833-F).

[31] Id.

[32] Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator (ONC), "HTI-4 Final Rule: Electronic Prescribing, I-Time Prescription Benefit and Electronic Prior Authorization Fact Sheet: Overview of HTI-4," p. 3 (July 2025).
[33] CMS, "Interoperability Standards and Prior Authorization for Drugs (CMS-0062)," (Fall 2024). This rule would propose new requirements for Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally facilitated Exchanges (FFEs).
[34] CMS, Interoperability Standards and Prior Authorization for Drugs (CMS-0062), (Fall 2024).
[35] 89 Fed. Reg. 8766 (Feb. 8, 2024), https://www.federalregister.gov/d/2024-00895/page-8766
[36] Workgroup for Electronic Data Interchange (WEDI), "CMS Interoperability and Prior Authorization Final Rule Survey," April 10, 2025. (Access may require free registration.).
[37] Percentage derived by the Virginia Bureau of Insurance from information contained in the 2023 Accident & Health Policy Experience Exhibit and the Supplemental Health Care Exhibit.
[38] California: CA SB1419 | 2021-2022 | Regular Session | Chaptered | LegiScan
[39] Tennessee: TN HB0869 | 2025-2026 | 114th General Assembly | LegiScan
[40] Utah: The directive was issued by Governor Cox. Press release can be accessed at 2022_09_06 One Utah Health Collaborative.pdf - Google Drive. September 6, 2022.
[41] Washington: HB 1357, passed in 2023 - WA HB1357 | 2023-2024 | Regular Session | LegiScan