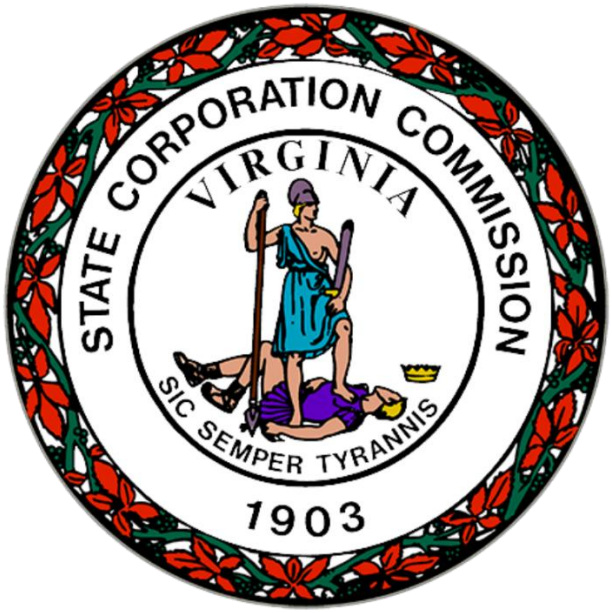
Report of the Electronic Prior Authorization Work Group

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 1055 of the 2026 Acts of Assembly



State Corporation Commission
Bureau of Insurance

November 1, 2026

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

November 1, 2026

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 Barbara A. Favola
Chair, Education and Health Committee
Senate of Virginia

The Honorable Rodney T. Willett
Chair, Health and Human Services Committee
Virginia House of Delegates

Dear Senators Deeds and Favola and Delegates Ward and Willett:

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 1055 of the 2026 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

In 2022, the General Assembly directed the State Corporation Commission (SCC), in coordination with the Office of the Secretary of Health and Human Resources, to convene a work group to examine electronic prior authorization (ePA) and real-time prescription benefit (RTPB) processes in the private commercial health insurance market.[1] Several legislative iterations later, the Electronic Prior Authorization Work Group is charged with (i) monitoring the implementation of ePA for medical items and services,[2] (ii) monitoring and considering options for making the prior authorization process for prescription drugs more prospective; and (iii) considering whether the scope of prior authorization metrics reporting should be expanded to prescription drugs.

The national mandate for impacted payers[3] to implement ePA in real time, and parallel state requirements for Virginia's private commercial health insurance market, have driven progress towards the work group's goal of ensuring payers and providers ultimately operate under a unified and consistent set of technical standards and requirements across both public and private commercial markets for the benefit of patients. One recent survey series by the Workgroup for Electronic Data Interchange (WEDI) shows that progress is being made: countrywide, 45% of payer respondents were 50 to 75% complete in implementing the medical prior authorization API (Application Programming Interface) required by CMS rule by January 1, 2027, up from 6% in an initial 2025 survey.[4] Usage is also accelerating. One large electronic health records (EHR) vendor reports that medical ePA-related transactions performed for the health systems they serve had jumped from 260,000 in Q4 2023, to 1.145 million in Q1 2025.[5]

The work group makes several key recommendations:

1. With many of the foundational standards and technologies already or soon to be in place, the work group recommends it continue to evaluate available implementation approaches leveraging the FHIR®-based APIs and distinguish among the underlying interoperability standards, implementation workflows, governance models, and supporting infrastructure, knowing the remaining opportunity lies in stakeholder collaboration around scalable implementation using existing national open standards and existing infrastructure. This could include evaluating the use of a single pathway to process ePA using open standards, non-proprietary software and doing so in real time.

2. The work group recommends that plans and providers evaluate the use of a single pathway to process ePA using open standards, non-proprietary software and do so in real time.

3. For those providers without a more comprehensive alternative to implementing prospective prior authorization, the work group recommends that they consider a phased approach to implementing prospective prior authorization beginning July 1, 2027, starting with frequently prescribed and/or high-cost drugs typically subject to prior

authorization, along with a notification and learning process for a specified time period, before recommending any specific compliance measures.

4. The work group recommends that any decision on expanding current prior authorization metrics reporting to include prescription drugs be deferred until its 2027 cycle consistent with its policy goal of aligning state ePA requirements with federal requirements to promote one unified and integrated process across all markets.

1. Introduction

Automation in real time is transforming the prior authorization process for prescription drugs and medical items and services. Together with other advances such as e-prescribing, it is revolutionizing workflows for a more efficient delivery of health care services. The scope and pace of change across all health insurance markets is increasing exponentially. From a regulatory standpoint, this is being driven in large part by the federal mandate for impacted payers to implement ePA and real-time processes and APIs, as well as parallel requirements in Virginia for the private commercial health insurance market. 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 federal developments for future alignment.

This work group has its genesis in chapters 284 and 285 of the 2022 Acts of Assembly. That legislation and the legislation which followed it,[6] accelerated Virginia's drive towards automation of the prior authorization process in the private commercial health insurance market for both prescription drugs and medical items and services, along with the provision of real-time, patient-specific benefit information to enrollees and contracted providers for covered prescription drugs. The legislation required carrier contracts with providers to include provisions for the implementation of ePA and RTPB for prescription drugs, beginning July 1, 2025, and to establish and maintain a prior authorization API for medical ePA, beginning January 1, 2027. The work group's charge was again revised during the 2026 Session of the General Assembly in chapter 1055 of the 2026 Acts of Assembly. Its current charge, and the focus of this report, is to:

(i) Monitor the implementation of ePA for medical items and services pursuant to § 38.2-3407.15:8 of the Code of Virginia (Code), including any relevant federal developments, industry progress and readiness to implement (ePA) for medical items and services; and policies supporting the effective and efficient adoption of ePA for medical items and services.

(ii) Monitor and consider options for revising the prior authorization process for prescription drugs from a less retrospective to a more prospective process; and

(iii) Consider whether the scope of prior authorization metrics reporting described in § 38.2-3407.15:8 of the Code should be expanded to include prescription drugs.

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 work group must submit its annual report 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 by November 1. This is its fifth annual report. It is submitted by the SCC 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.

This work group held six meetings between May and September 2026, with a summary of each included in Appendix A.

2. Findings and Recommendations

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

A. Monitoring the Implementation of Medical ePA

Throughout this process, Virginia has been working to align its medical ePA standards and policies with federal regulatory requirements for impacted payers such as those under Medicare Advantage and Medicaid. Pursuant to subsection B of § 38.2-3407.15:8 of the Code, effective January 1, 2027, any provider contract between a carrier and a participating health care provider must contain specific provisions requiring:

- Carriers to establish and maintain a prior authorization API for medical items and services; and

- Participating providers to ensure that any EHR system owned or contracted for by the provider to maintain an enrollee's health record can access the carrier's prior authorization API. Providers can request an undue hardship waiver.

This mandate for Virginia's private commercial health insurance market to implement medical ePA follows publication of the Centers for Medicare and Medicaid Services' (CMS) final rule on "Advancing Interoperability and Improving Prior Authorization" (CMS-0057-F)"[7] (2024 Prior Authorization Rule). This rule took effect on April 8, 2024, and requires impacted payers[8] to implement and maintain a specific prior authorization

API for medical ePA using the Health Level Seven International® (HL7®) FHIR® standard.[9] The prior authorization API must be populated with a payer's list of covered items and services, identify documentation requirements, and support prior authorization requests and responses. It must be implemented by January 1, 2027. While this rule does not apply to Virginia's private commercial market, Virginia has opted to align itself with federal ePA requirements. For that reason, the work group is directed to monitor relevant federal developments. Separately, in June 2025, more than two dozen of the largest health plans pledged to improve prior authorization processes by standardizing ePA, including the development of standardized data and submission requirements using FHIR®-based APIs by January 1, 2027.[10]

1. Federal Developments

There has been significant federal activity in the year since the work group submitted its 2025 Annual Report to the General Assembly. Many are proposed rules that might or might not become final rules, be adopted as part of a different rule, or potentially delay current policies such as the implementation date of APIs. In the case of the API implementation date, Virginia has statutory contingency language.[11] This section highlights some of the most consequential developments.

Findings

A.1.1. On December 22, 2025, the Office of the Assistant Secretary for Technology Policy (ASTP) and the Office of the National Coordinator for Health IT (ONC), published a new proposed rule to update its health IT certification program. The "Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity (HTI-5-P)," will support the drive towards implementing FHIR®-based APIs.[12] The proposed rule will "aggressively reduce and remove long-standing functionality-oriented and non-FHIR®-based certification criteria from the Certification Program"[13] in favor of a certification program that supports FHIR®-based APIs. In its executive summary to the proposed rule, ASTP/ONC declares that "America's interoperability arc in health care has bent decisively toward FHIR®-based APIs."[14]

A.1.2. On April 14, 2026, CMS published a new proposed rule entitled "2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P)," (2026 Prior Authorization for Drugs Proposed Rule), as a follow up to its 2024 Prior Authorization Rule. This proposed rule extends many existing interoperability requirements for the prior authorization of medical items and services to drugs to further reduce patient and provider burden. It proposes the use of the FHIR®-based interoperability standard and specific versions of associated DaVinci Burden Reduction Implementation Guides (IG).[15] These can be used to support drugs under a medical benefit. Impacted payers would be required to support ePA for all drugs through the Prior Authorization API (medical benefit) and National Council for Prescription Drugs (NCPDP) standards (pharmacy benefit) beginning October 1, 2027. Importantly, the proposed rule would replace the HIPAA 278 prior authorization transaction with the

FHIR®-based APIs. Some have said that in doing so, the rule is effectively expanding the footprint of its 2024 Prior Authorization Rule to private commercial health insurance plans.

A.1.3. On May 15, 2026, nearly one year after the insurance industry pledged to implement a six-point plan to streamline prior authorization processes across all insurance markets, including standardizing ePA using FHIR®-based APIs and answering at least 80% of prior authorization approvals in real time by 2027, the U.S. Department of Health and Human Services launched the ePA use case."[16] Part of the CMS Health Technology Ecosystem, this initiative is designed to expand the adoption of medical ePA beyond the minimum compliance requirements. It now includes pledges from a broader group of health care organizations such as provider groups, EHR vendors, and health systems.[17]

A.1.4. On July 16, 2026, CMS published its "CY 2027 Physician Fee Schedule for Medicare and Medicaid Programs Proposed Rule (CMS-1848-P)."[18] In harmony with the Inpatient Prospective Payment Systems (IPPS) Final Rule discussed in finding A.1.5, this rule proposes to change the CMS' ePA measure under Medicare's Merit-based Incentive Payment System (MIPS) "promoting interoperability" performance category from required to optional for CY 2027, then back to required for CY 2028. It also adds a new measure for ePA for prescription drugs. Starting with CY 2027, the CMS is proposing to align the definition of the ONC's Certified Electronic Health Record Technology (CEHRT) with the applicable ONC proposals to remove non-FHIR®-based certification criteria from the ONC's proposed rule on the Health IT Certification Program (HTI-5).

A.1.5. On August 4, 2026, CMS published its "FY 2027 Hospital Inpatient Prospective Payment System Final Rule (CMS-1849-F)," (IPPS Final Rule). Effective October 1, 2026, this rule makes the CMS ePA measure in the 2024 Prior Authorization Rule an optional bonus measure for the CY 2027 EHR reporting period and a required measure beginning with the CY 2028 EHR reporting period. This one-year delay has led some to speculate that the compliance date for the implementation of the medical ePA API on January 1, 2027, could be delayed to 2028 as well. The WEDI has proposed establishing CY 2027 as a "testing and evaluation year to keep stakeholders moving forward but avoid imposing enforcement action."[19] The IPPS Final Rule also adopts certain versions of the HL7 FHIR®-based Da Vinci IGs for prior authorization from the 2026 Prior Authorization for Drugs Proposed Rule or the ONC's CEHRT program.[20]

A.1.6. The HHS Health Technology Ecosystem Initiative launched in July 2025 is underway and perusing real-world efforts. What started out as roughly 60 companies/pledgees now has over 1,000 organizations pledging to improve data interoperability and fluidity. It includes numerous pledge categories, including prior authorization,[21] with the latest pledges including pharmacy and RTPB. Future initiative details and outcomes are pending.

Recommendations

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

A.1.2. The work group encourages participating stakeholders to take an active role in related federal rulemaking to help shape policies that advance ePA in real time for medical items and services and reduce the burden on patients in Virginia.

2. Industry Readiness

Findings

A.2.1. The WEDI has conducted a series of surveys tracking the implementation of the CMS 2024 Prior Authorization Rule by payers, providers, and others.[22] In its most recent 2026 survey, WEDI found that 45% of payers were 50 to 75% complete in implementing the prior authorization API required by CMS by January 1, 2027, up from 6% in its initial 2025 survey.[23] The percentage of payers that were at 0% complete dropped from 43% to 10%. However, WEDI believes that "industry still has a long way to go" to implement the 2024 Rule. It found that "payers are reporting challenges associated with digitizing PA policies," and that there is a "continued need for industry education and testing."[24] 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.[25]

A.2.2. The API's value will depend in part on the extent to which providers integrate and actively use these capabilities within the workflows. Provider payment incentives under MIPS and IPPS may help accelerate the adoption and maximize the benefit of the prior authorization API.[26]

A.2.3. The Medical Society of Virginia sampled some large and small medical practices of different specialties to assess implementation on the ground.[27] Most appear ready for implementation and say it is going smoothly. A number of practices, especially those that are smaller, are relying heavily on their EHR vendor to maintain compliance. This reliance on EHR vendors is a sentiment echoed by the Virginia Hospital and Healthcare Association on behalf of health systems. Physician practices typically buy products off the shelf and assume that the EHR provider is including any required implementations. Larger practices with more sophisticated IT infrastructure do some checks and balances to increase their efficiency. Overall, the response from single-practitioner practices across specialties, has been characterized as "pretty good." Health systems are wondering how the new policies will be translated through their EHR without requiring a lot of back and forth, denials, and phone calls.[28]

A.2.4. According to the Office of the Secretary of Health and Human Resources, as of October 1, 2026, no providers had filed waiver requests for undue hardship with the appropriate regulatory authority within the Secretariat pursuant to § 38.2-3407.15:8 of the Code.

A.2.5. Physicians and health systems are incentivized to use CEHRT through Medicare's MIPS payment program for physicians and the IPPS for health systems. CEHRT includes payer prior authorization APIs under the 2024 Prior Authorization Rule. According to KFF, nationally, "virtually all (98%) of non-pediatric physicians participate in the Medicare program."[29] Many physicians and health systems that serve Medicare patients and presumably use CEHRT also serve patients in Virginia's private commercial health insurance market.

A.2.6. According to a Virginia Health Care Foundation survey, "50% of survey respondents (rural providers) report having fully implemented a CEHRT platform, with significant variation by provider type." In addition, "27% of survey respondents report having fully implemented electronic data exchange with external health care providers. Several interviewees reported having CEHRT but not having the financial or technical resources to enable (electronic data) exchange."[30]

A.2.7. As part of its assessment, the work group received data from Epic Systems Corporation (Epic) – a large healthcare software company. Epic reports a continuing increase in the adoption of medical ePA. Countrywide, the percentage of Epic organizations using medical ePA increased from approximately 7 percent in December 2023, to around 20 percent in December 2025. For Virginia health systems using Epic, adoption has also grown, though from a lower baseline. Also on a countrywide basis, health systems served by Epic performed approximately 260,000 medical ePA-related transactions per quarter in Q4 2023. By Quarter 1 of 2025, the number of such transactions had jumped to 1.145 million per quarter.[31]

A.2.8. As part of the Rural Health Transformation Program, the Virginia Health Care Foundation will award $14 million under the Provider Interoperability sub-initiative and between $7 million to $9 million under the Provider Productivity sub-initiative for Year 1 of the program. Provider interoperability funds will help independent rural providers modernize their digital infrastructure. This funding could be used to support projects that advance the use of ePA and EHR systems by rural providers. This could help "clos(e) the technology gap that often prevents rural providers from keeping pace with EHR . . . advancements."[32] Provider productivity funds will "support adoption of digital productivity tools, including AI-enabled decision-support, documentation, and workflow automation, to reduce administrative burden, ease provider burnout, and allow rural clinicians to focus more of their valuable time on patient care."[33]

Recommendations

A.2.1 With many of the foundational standards and technologies already or soon to be in place, the work group recommends it continue to evaluate available implementation approaches leveraging the FHIR®-based APIs and distinguish among the underlying interoperability standards, implementation workflows, governance models, and supporting infrastructure, knowing the remaining opportunity lies in stakeholder collaboration around scalable implementation using existing national open standards and existing infrastructure. This could include evaluating the use of a single pathway to process ePA using open standards, non-proprietary software and doing so in real time.

A.2.2. The work group recommends that plans and providers evaluate the use of a single pathway to process ePA using open standards, non-proprietary software and do so in real time.

A.2.3. The work group recommends that the impacted stakeholder groups continue to inform and educate their membership of the requirements in the lead up to the January 1, 2027, medical ePA implementation date.

A.2.4. The work group recommends that provider organizations consider applying for funding under Virginia's Rural Health Transformation Program, as applicable. As the trade association for Virginia's health systems, the Virginia Hospital and Healthcare Association is prepared and actively assisting hospital leadership and program implementation staff with Rural Health Transformation Program navigation, including for the purpose of helping to modernize their workflows and/or EHR systems to facilitate ePA and RTPB.

B. A More Prospective Prior Authorization Process for Prescription Drugs

Because of the adverse impact on patient access to health care resulting from the system-level inefficiencies, duplication, and waste that result from a retrospective workflow for prior authorization for prescription drugs, the work group devoted considerable time to hearing from stakeholders and discussing ways to make it more prospective and, by doing so, improve the patient experience.

Despite the availability of the necessary technologies and standards to process prior authorizations for prescription drugs prospectively, retrospective prior authorization is a significant challenge in provider workflows for Virginia pharmacists. It occurs after the physician has transmitted the prescription to the pharmacy. It results in a loop process, requiring additional back-and-forth communication among the provider, pharmacy, and patient, without the filtering one would expect with the electronic processes that payers, providers, and pharmacists have put in place. Prior authorization that is prospective occurs before the provider has sent the prescription to the pharmacy. This results in an efficient straight-line process from the provider to the pharmacist.

The retrospective process is reactive and impairs a patient's access to treatment. Patients may travel to the pharmacy and leave frustrated because their medication is not ready. This process can also shift prescription drug costs to patients: 79% of physicians report that patients sometimes wind up paying out-of-pocket.[34] In some cases, pharmacy staff must explain to the patient that the prescribed drug is not covered by the patient's health plan, causing frustration for the patient and concern over their ability to pay out-of-pocket or refusing treatment altogether, often without informing the pharmacist. Pharmacy staff must then return the medication to stock, sometimes, resulting in unwanted or unneeded stock or wasted inventory. Finally, the retrospective process can worsen patient outcomes due to prior authorization-related delays. These have been linked to emergency room visits 42% of the time and hospitalizations 29% of the time.[35]

With a retrospective process, the pharmacy must use considerable resources to notify the provider that prior authorization is required. For example, the pharmacy staff may have to use a third-party vendor or some other modality like a fax. The provider must then submit the required prior authorization after having already sent the prescription to the pharmacy. Some vendors do support a discrete field or similar within the EHR that shows the prior authorization status of a prescription. With this tool, pharmacy staff can choose to hold off on any automation, although doing so is likely to require significant change in pharmacy workflow and prescription queue management. A prospective process, informing the patient of the prior authorization determination at the point of prescribing, would render this tool unnecessary. However, pharmacies are already tracking this in a less structured way by receiving a rejection, placing the prescription on hold, and attempting to notify the patient, and then messaging the prescriber. This is an unreimbursed service provided by pharmacists and disrupts the current workflow, wastes valuable time, and creates further interruptions with patients and providers checking on its status.

Incorrect information from payers can result in either under-flagging (prior authorization is not requested but is necessary which leads to retrospective processing of prior authorizations), or over-flagging (the prior authorization is requested when unnecessary). This can become a burden on the provider's side.

Findings

B.1.1. A prospective ePA workflow for prescription drugs benefits the citizens of the Commonwealth and serves the best interests of patients by affording them better access to health care and better health care. Retrospective prior authorizations results in duplicative processing and waste at the expense of patient care.

B.1.2. The necessary technologies and standards to process prior authorizations prospectively are available, continuing to evolve, and can be facilitated within the workflow and systems that have adopted the NCPDP SCRIPT Standard ePA

Transactions. The availability and support of necessary EHR functionalities and provider adoption is the key. Potential workflow changes need to be identified.

B.1.3. It is critically important that EHRs streamline ePA and real-time processes and align them with clinical workflows to drive the adoption of prospective prior authorization and reduce additional administrative burden on providers. This will help encourage providers to use the system.

B.1.4. Prospectively processing prior authorizations for prescription drugs requires payers and/or their PBMs to provide prescribers with the correct information to determine if prior authorization is necessary, including plan level formulary and benefit information and RTPB integration.

B.1.5. The NCPDP SCRIPT Standard© Version 2023011 includes the PANotification transaction. PANotification is intended to improve electronic communication between prescribers and pharmacists and reduce duplicate submissions to payers and alert them when a prior authorization has been requested or determination has been received. Its value depends on whether the provider/EHR transmits the information and whether the pharmacy's systems are configured to receive and operationalize it. It does not eliminate the potential for patient confusion or delays. CMS adopted this standard with a compliance date of January 1, 2028.[36] The ONC requires health IT certified to the electronic prescribing criterion to support Version 2023011 for EHR certification beginning January 1, 2028.[37]

B.1.6. While CMS rules require impacted payers to use a specific version of the NCPDP SCRIPT standard (Version 2023011), Virginia does not.[38] However, federal rules do not require use of the PANotification transaction for specific prior authorization workflows but do require that it be supported.

Recommendations

B.1.1. The work group recommends making prospective prior authorization for prescription drugs in the private commercial market the stated policy objective of the Commonwealth in the best interests of patients, and that all parties work together to create a pathway to achieve this objective.

B.1.2. Working with all major stakeholders, the work group encourages providers to implement prospective prior authorization for prescription drugs and initiate it along with real-time processes during the patient encounter so that coverage requirements, costs, alternative therapies, and prior authorization requirements can be addressed as close to the prescribing decision as practicable. The work group received testimony that the necessary real-time processes integral to implementation of prospective prior authorization can face headwinds from health care brokers with a stake in the status quo and make them unaffordable for some providers.

B.1.3. For those providers without a more comprehensive alternative to implementing prospective prior authorization, the work group recommends that they consider a phased approach to implementing prospective prior authorization beginning July 1, 2027, starting with frequently prescribed and/or high-cost drugs typically subject to prior authorization, along with a notification and learning process for a specified time period, before recommending any specific compliance measures. The work group trusts that once this process is adopted and used for a few classes of medications, prescribers and their staff will experience the positive impact on access and patient care, similar to when e-prescribing was adopted over a decade ago.

B.1.4. The work group recommends that EHRs supporting prospective prior authorization workflows include appropriate mechanisms for communicating prior authorization status to patients, including whether additional action is required and when a coverage determination has been made, and be evaluated to ensure they receive consistent information whether they contact the provider, health plan, or pharmacy, with the goal of reducing patient confusion, avoidable delays, and abandonment of treatment.

B.1.5. So that prospective prior authorization functionality at the point of prescribing is enabled and used consistently across affiliated providers and not impeded by any delays from coding and other clinical documentation practices, the work group recommends that EHR vendors coordinate EHR configuration and implementation to optimize health system and provider practice workflows to support prospective prior authorization.

B.1.6. The work group recommends that providers and health systems work with their EHR vendors to ensure their systems support the PA-related transactions and status information available under the applicable NCPDP SCRIPT Standard©, including PANotification under the new SCRIPT Standard© Version 2023011, and whether that functionality and a vendor-specific prior authorization status field can be incorporated into existing workflows.

B.1.7. The work group recommends that plans make sure the information necessary to make prior authorization determinations is correct and available to providers.

C. Extension of Metrics Reporting to Prescription Drugs

Effective January 1, 2027, subsection F of § 38.2-3407.15:8 of the Code requires each health carrier "to make available by posting on its website no later than March 31 of each year the prior authorization data for prior authorizations covered by this section for the previous calendar year at the health plan level for all metrics required for compliance with federal law and the regulations of the CMS, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c)."

These metrics include:

- a list of all items and services that require prior authorization;
- the percentage of standard prior authorization requests that were approved, denied, or approved after appeal, aggregated for all items and services;
- the percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;
- the percentage of expedited prior authorization requests that were approved and denied, aggregated for all items and services; and,
- the average and median time that elapsed between the submission of a request and a determination by the . . . plan, for standard and for expedited prior authorizations, aggregated for all items and services.

Subsection C of that same Code section also requires carriers to "make available through one central location on the carrier's publicly accessible website or other electronic application, the list of services and codes for which prior authorization is required."

The work group is charged with considering whether the scope of prior authorization metrics reporting described in § 38.2-3407.15:8 of the Code should be expanded to include prescription drugs.

Findings

C.1.1. The work group finds CMS is in the process of considering its 2026 Prior Authorization for Drugs Proposed Rule which would extend metrics reporting for medical items and services to drugs. Since it remains pending, federal policy on this question is not yet settled.

Recommendations

C.1.1. After discussing the substance of the charge, the work group recommends that any decision on expanding current prior authorization metrics reporting to include prescription drugs be deferred until its 2027 cycle consistent with its policy goal of aligning state ePA requirements with federal requirements so as to promote one unified and integrated process across all markets.

D. Policies Supporting Implementation

The work group makes no additional findings or recommendations on policies supporting the implementation of medical ePA in this year's report.

3. Looking Ahead to 2027

Going forward, the work group intends to engage more intentionally with the Electronic Health Records Association because of the key role EHRs play in facilitating the successful and timely transition to ePA in real time by the provider and payer communities in Virginia. For this reason, the work group recommends that an EHR vendor or association representative be added as a designated work group participant, either through legislation or by work group invitation. Otherwise, none of the work group's recommendations necessarily require legislation to implement.

Appendix A. Summary of 2026 Work Group Meetings

The work group met six times between May and September during the 2026 reporting period.

May 20

This meeting focused on federal developments related to ePA since publication of the work group's 2025 Annual Report on November 1, 2025. It featured a CMS presentation of its new proposed rule on interoperability standards and prior authorization for drugs (2026 Prior Authorization for Drugs Proposed Rule). That was preceded by a presentation on the latest national developments from HL7 as well as developments at the state level. In addition to these updates, work group support staff provided a brief recap of the 2025 ePA Work Group Report, and HB 484 enacted by the Virginia General Assembly during its 2026 session. This legislation implemented work group recommendations related to medical ePA, retrospective versus prospective prior authorization, and the work group charge.

June 22

This meeting focused on medical ePA implementation and readiness. It featured a presentation from the WEDI on the results of its third-in-a-series survey of payer and provider readiness to implement medical ePA for federal programs by January 1, 2027. With an eye on identifying opportunities to assist rural providers with their health IT infrastructure capabilities, the work group received a presentation on Virginia's Rural Health Transformation Program and two sub-initiatives administered by the Virginia Health Care Foundation of greatest relevance to the work group charge: the Provider Interoperability and Provider Productivity sub-initiatives. The work group closed out the meeting with a discussion of its charge related to establishing metrics for prescription drug ePA. The work group preliminarily agreed to defer work on this issue until its 2027 cycle to see whether and how CMS resolves this matter at the federal level.

July 20

This meeting included an action item on metrics for prescription drug prior authorization, with the work group unanimously approving a motion to defer consideration of this part of its charge until its 2027 cycle. It then received two reports on medical ePA implementation and readiness: one from a health plan perspective by Elevance Health and another from a provider perspective by MultiCare Health. This was followed by a robust discussion concerning the work group charge related to identifying options for making the prior authorization process for prescription drugs more prospective and less retrospective. Various perspectives were shared by pharmacists, EHR/health IT vendors, providers, health plans, and others. The work group decided to carry the discussion and consideration of any proposals over to its August meeting.

August 18

This meeting began with an overview of the IPPS Final Rule and the implications for health system and provider implementation of medical ePA. It also noted the release of the Request for Applications by the Virginia Health Care Foundation under the Rural Health Transformation Program and related announcements concerning the submission and award dates for project funding. These items of note were followed by remarks from representatives of the Medical Society of Virginia and the Virginia Hospital and Healthcare Association on medical ePA implementation and readiness. The health systems representative also spoke to the SmartHealth initiative in Delaware and its possible relevance as a health care utility and vehicle for implementation of medical ePA in Virginia. Discussion from the July meeting on the prior authorization process for prescription drugs continued, with a brief presentation of the retrospective and prospective workflow by the NCPDP and consideration of a proposal from pharmacists that would state a work group preference for a prospective process and require a phased implementation for certain classes of drugs such as GLP-1s and other high-cost drugs. The work group was given time to go back and review this specific proposal as well as a lengthy set of possible findings and recommendations on this issue more broadly and share any written comments with the work group by late August as well as any suggested findings and recommendations related to any of the work group's charges for including in its 2026 Annual Report.

September 10

The work group considered its initial draft 2026 Annual Report, before circulating it for a one-week review period following this meeting. There was agreement that the work group facilitator would make any suggested non-substantive editorial revisions, before presenting a final report to the work group for approval either at a subsequent meeting or via email.

September 18

The work group met to approve a consensus final 2026 Annual Report for internal review by the SCC and submission to the General Assembly by November 1.

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

Endnotes

[1] Chapter 284 of the 2025 Acts of Assembly extended the term of the existing ePA Work Group from November 1, 2025, to November 1, 2028. In 2026, the General Assembly passed legislation recommended in the work group's 2025 Annual Report revising its charge to require it to consider extending prior authorization metrics reporting to prescription drugs and consider options for making the prescription drug ePA process more prospective and less retrospective.
[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 (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" do not include drugs that are subject to the requirements of § 38.2-3407.15:2.
[3] 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.
[4] Presentation by Robert Tennant, Executive Director, Workgroup for Electronic Data Interchange (WEDI), to the ePA Work Group, Slide 12, June 22, 2026.
[5] Data provided at the request of the ePA work group by Epic Systems Corporation via email from Tim Stolldorf, August 28, 2026.
[6] In 2022, the General Assembly 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[6] and 38.2-3407.15:7 of the Code. In Chapter 284 of the 2025 Acts of Assembly, the General Assembly subsequently extended the term of the work group from November 1, 2025 to November 1, 2028. It 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.
[7] CMS, "Advancing Interoperability and Improving Prior Authorization (CMS-0057-F)," 89 Fed. Reg. 8758 (February 8, 2024).
[8] 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 QHP issuers offering a QHP on a federally facilitated exchange.
[9] 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. 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." 89 Fed. Reg. 8761 (Feb. 8, 2024), https://www.federalregister.gov/d/2024-00895/page-8761
[10] AHIP, "Health Plans Take Action to Simplify Prior Authorization," June 23, 2025
[11] Per subsection B.6. of § 38.2-3407.15:8. of the Code (effective January 1, 2027) "A carrier shall implement such prior authorization application programming interface by January 1, 2027, or any other effective date subsequently issued by the (CMS), including those related to enforcement delays and suspensions… ."
[12] https://healthit.gov/regulations/hti-rules/hti-5-proposed-rule/ (viewed on August 24, 2026).
[13] P. 60972 Federal Register/Vol. 90, No. 245/Monday, December 29, 2025.

[14] P. 60972 Federal Register/Vol. 90, No. 245/Monday, December 29, 2025.
[15] These include the Coverage Requirements Discovery (CRD) IG, the Documentation Templates and Rules (DTR) IG, and the Prior Authorization Support (PAS) IG.
[16] https://www.cms.gov/initiatives/health-technology-ecosystem/overview/early-adopters-all-pledgees/additional-use-case/additional-use-case-electronic-prior-authorization.
[17] DistilINFO Publications, "Hospitals and EHR Vendors Join CMS Pledge," May 7, 2026.
[18] CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.
[19] Presentation by Robert Tennant, Executive Director, WEDI, to the ePA Group, June 22, 2026.
[20] These standards include the following: (i) HL7—CRD IG, Version 2.2.1 - STU 2.2; (ii) HL7 FHIR® Da Vinci—DTR IG, Version 2.2.0 - STU 2.2; (iii) HL7 FHIR® Da Vinci PAS IG, Version 2.2.1 - STU 2.2; (iv) HL7 FHIR® CARIN IG for Blue Button®), Version 2.2.0 - STU 2.2; (v) HL7 FHIR® Da Vinci PDex IG, Version 2.1.0 - STU 2.1; (vi) HL7 FHIR® Da Vinci PDex Plan Net IG, Version 1.2.0 - STU 1.2; and (vii) HL7 FHIR® Da Vinci CDex IG, Version 2.1.0 - STU 2.1.
[21] The prior authorization pledge for the prior authorization use case: "We pledge to advance electronic prior authorization beyond minimum compliance requirements by implementing interoperable, end-to-end workflows across medical prior authorization processes. We commit to working collectively across stakeholders to support alignment, seamless data exchange, and measurable improvements across medical prior authorization workflows consistent with CMS-0057-F." CMS at https://www.cms.gov/initiatives/health-technology-ecosystem/overview/early-adopters-all-pledgees/additional-use-case/additional-use-case-electronic-prior-authorization.
[22] WEDI, "CMS Interoperability and Prior Authorization Final Rule Survey," April 10, 2025. (Access may require free registration.)
[23] Presentation by Robert Tennant, Executive Director, WEDI, to the ePA Work Group, Slide 12, June 22, 2026.
[24] Presentation by Robert Tennant, Executive Director, WEDI to the ePA Work Group, June 22, 2026.
[25] 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. This 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.
[26] Presentation by Sheljina Ibrahim Kutty on behalf of Elevance Health to the Virginia Electronic Prior Authorization Work Group, July 20, 2026.
[27] Remarks by Scott Castro on behalf of Medical Society of Virginia to the Virginia Electronic Prior Authorization Work Group, August 18, 2026.
[28] Remarks by Carrie Monger on behalf of the Virginia Hospital and Healthcare Association to the Virginia Electronic Prior Authorization Work Group, August 18, 2026.
[29] Alex Cottrill, Nancy Ochieng, and Tricia Neuman, KFF, "How Many Physicians Have Opted Out of the Medicare Program?," January 17, 2025.
[30] Presentation by Ben Barber, Rural Health Officer, Virginia Health Care Foundation, to the Virginia Electronic Prior Authorization Work Group, Slide 10, June 22, 2026.
[31] Data provided at the request of the ePA work group by Epic Systems Corporation via email from Tim Stolldorf, August 28, 2026
[32] Virginia Department of Medical Assistance Services, Rural Health Transformation Program Application: CMS-RHT-26-001: Virginia Rural Vitality - Project Narrative, at 21.
[33] The Virginia Health Care Foundation, Request for Applications, "Virginia Rural Health Transformation Program Provider Productivity: Technology that Makes Time for Care," at 4.
[34] Tanya Henry, American Medical Association, "Prior authorization delays care—and increases health care costs," August 12, 2024 (viewed on September 4, 2026).
[35] Id.
[36] Medicare Program; Medicare Prescription Drug Benefit Program; Health Information Technology Standards and Implementation Specifications (CMS-9123-F)
[37] The ASTP/ONC's Health Data, Technology, and Interoperability (HTI-4) Final Rule.

[38] 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 NCPDP's RTPB Standard© as the standard for prescriber RTPB tools supported by Medicare Part D plan sponsors, beginning January 1, 2027.