JOINT COMMISSION ON HEALTH CARE

2023 ANNUAL REPORT

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #288

COMMONWEALTH OF VIRGINIA
RICHMOND
2024

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

Joint Commission on Health Care

Members

Chair

The Honorable Delegate Rodney T. Willett*

Vice Chair

The Honorable Senator Ghazala F. Hashmi

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Senator Barbara A. Favola
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Senator L. Louise Lucas
Senator Stella G. Pekarsky*
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Delegate Patrick A. Hope
Delegate Robert D. Orrock, Sr.
Delegate Marcia S. Price*
Delegate Atoosa R. Reaser*
Delegate Mark D. Sickles*
Delegate Howard Otto Wachsmann, Jr.*

*New members as of April 2024

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JOINT COMMISSION ON HEALTH CARE

Delegate Rodney T. Willett, Chair *Senator Ghazala F. Hashmi, Vice Chair*

June 14, 2024

The Honorable Glenn Youngkin
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
Pocahontas Building
Richmond, Virginia 23219

Dear Governor Youngkin and Members of the General Assembly:

Please find enclosed the annual report of the Joint Commission on Health Care. This report, which summarizes the activities of the Commission in 2023 and legislative action taken by the Commission during the 2024 session, fulfills the requirements of § 30-168.5 of the Code of Virginia.

This and all other reports and briefings of the Joint Commission on Health Care can be found at jchc.virginia.gov.

Respectfully submitted,

Rodney T. Willett, Chair

Sarah Stanton, Executive Director
Joint Commission on Health Care
411 E. Franklin Street, Suite 505 / Richmond, VA 23218

Joint Commission on Health Care 2023 Annual Report

The Joint Commission on Health Care (JCHC), a standing commission of the General Assembly, was established in 1992 to continue the work of the Commission on Health Care for All Virginians. The Code of Virginia, Title 30, Chapter 18, states in part: "The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services."

The Joint Commission on Health Care is comprised of 18 legislative members. Eight members are Senators appointed by the Senate Committee on Rules, and ten members are Delegates appointed by the Speaker of the House. Senator George Barker served as Chair and Delegate Robert Orrock served as the Vice Chair in 2023.

JCHC Strategic Priorities

JCHC members identified four strategic priorities to guide the work of the Commission: Accessibility, Affordability, Quality, and Equity. These strategic priorities come from the JCHC authorizing language in the Code of Virginia, which charges the Commission to work towards implementing "the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care." The Code of Virginia also charges the Commission with ensuring "the availability of quality, affordable and accessible health services."

The JCHC is working to make progress toward achieving a health care system in Virginia that meets these goals. The JCHC maintains a Virginia Health Care Dashboard, which measures the current state of these goals using selected metrics. Additionally, each of the studies that members directed staff to conduct this year (2024), is directly related to improving at least one of the four strategic objectives (see Table 1 on page 8).

Staff Reports and Legislative Activities

The JCHC works to further the strategic objectives through staff research and analysis, guest presentations from key stakeholders, and developing recommendations for legislative action. Three staff studies and two briefings were presented to the members during 2023.

- Team-based Care Approaches to Improve Health Outcomes;
- Obesity and Eating Disorders Prevention and Treatment in Virginia;

- Vertically Integrated Carriers and Providers;
- Prescription Drug Affordability briefing; and
- Health Care Workforce briefing.

Team-based Care Approaches to Improve Health Outcomes

Report Summary

Team-based care is the provision of services by at least two health care professionals who work collaboratively with patients and their caregivers to accomplish shared goals. While team-based care occurs in all health care settings, its impact on population health is most apparent in primary care practices. Effective primary care practice teams have a defined, bounded membership with shared goals and interdependent responsibilities for care delivery. Implementing team-based primary care to support patients with increasingly complex medical needs requires additional resources, which some primary care practices cannot access.

Team-based care is evidence-based but reimbursement for behavioral health and pharmacy services is limited

Practice teams have a positive impact on chronic conditions and have evolved to integrate behavioral health and pharmacy services. Health care professionals cited lack of insurance coverage for integrated behavioral health services and medication therapy management delivered via telehealth as significant barriers to providing much-needed services to patients.

The impact of state-funded incentive programs to address primary care workforce shortages is unclear

Successful team-based care depends on a robust health workforce. Practices rated difficulty recruiting or retaining clinical staff as the top factor limiting optimal implementation. Virginia has invested state funds in multiple primary care work force incentive programs; however, the value and impact of these programs is unknown.

Practices need implementation support to transition from traditional to team-based primary care

Team-based care is cost-effective but requires up front investments in infrastructure, staffing, and training that may not be attainable for all practices. With additional resources, the existing structure of Virginia's regional Area Health Education Centers (AHECs) could be leveraged to provide implementation support to smaller or independently owned practices.

Current fee-for-service payment models are a barrier to team-based care sustainability

Stakeholders and survey respondents reported that the current fee for service payment models are a significant deterrent to sustaining team-based primary care. Virginia could support expansion of team-based care using value-based payment models with Medicaid beneficiaries.

Legislative Impact

JCHC members introduced budget amendments for DMAS to establish guidelines for statewide Collaborative Care Model program; and for the Virginia Health Center for Innovation (VCHI) to expand initiative to adopt standardized team-based performance criteria and payment methodologies for payers.

(See Appendix A, Table 2 for a full listing of all policy options and legislative action from this study.)

Obesity and Eating Disorders Prevention and Treatment in Virginia

Report Summary

While obesity and eating disorders fall along a spectrum of weight-related problems, obesity is not considered an eating disorder. Obesity and eating disorders are independent medical conditions that each come with severe physical and mental health consequences.

Coverage of obesity prevention and early intervention services varies by insurer

Virginia Medicaid currently covers preventive services for children and adults, including physical exams and nutrition counseling. Two Medicaid MCOs piloted an evidence-based prevention program, the Diabetes Prevention Program, that successfully targets people who are at high risk for type 2 diabetes by promoting a change in lifestyle factors for modest weight loss. The program could benefit people with obesity; however, this program is not currently a covered Medicaid benefit. The Virginia EHB benchmark plan covers counseling services related to nutrition as a preventive health benefit but does not cover behavioral interventions for obesity. Some individual and small group plans also exclude medical nutrition therapy as a treatment for obesity.

Weight loss medications are not covered in the Virginia Essential Health Benefits (EHB) benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan outlines services which must be covered by individual and small group plans. Also, the Virginia EHB benchmark plan specifically excludes coverage for weight loss drugs. Consequently, there are no individual or small group plans that cover these services. Medicaid requires prior authorization for weight loss drugs.

Weight loss surgery is not covered in the Virginia Essential Health Benefits benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan specifically excludes coverage for weight loss surgery, which is similar to most states. Twenty-three states cover bariatric surgery through their state EHB benchmark. Coverage is limited to the individual and small group market. Virginia Medicaid covers bariatric surgery when medically necessary.

Limited reimbursement and coverage of eating disorder services are major barriers to treatment

Eating disorder treatment providers reported unsustainably low reimbursement rates and difficult rate negotiations with commercial insurance companies. Medicaid does generally cover some eating disorder treatment, but there is not an established rate for eating disorder services. Providers can participate in single-case agreements with Medicaid to provide services, when possible.

Lack of alignment in prior and continued authorization requirements and medical necessity among insurers can create administrative barriers and delay care

Eating disorder treatment usually requires prior authorization based on an insurer's medical necessity criteria before services will be covered. Insurers can use discretion on what clinical guidelines they use to authorize services, resulting in differences in eating disorder treatment coverage across plans and carriers. Additionally, insurers often require continued stay authorization and can deny coverage if the patient no longer meets their medical necessity criteria. However, when the insurer fails to provide their definition of medical necessity, providers find it challenging to justify ongoing treatment.

Methods to ensure compliance with federal and state mental health parity laws continue to evolve

Non-quantitative treatment limitations (e.g., prior authorization requirements) may not indicate a mental health parity violation, but current state processes for oversight and enforcement of parity may not effectively identify and reduce barriers to mental health treatment. Some states have updated their mental health parity laws to increase transparency and ensure behavioral health services are covered to the same extent as medical surgical benefits.

Legislative Impact

JCHC members introduced budget amendments for a plan to incorporate Diabetes Prevention Program as covered Medicaid service; for DMAS to develop comprehensive plan for eating disorder treatment services; and for the Bureau of Insurance (BOI) to develop guidance for a definition of nutritional counseling and removing prior authorization for eating disorder treatment.

(See Appendix A, Table 3 for a full listing of all policy options and legislative action from this study.)

Vertically Integrated Carriers and Providers

Report Summary

Vertical integration in health care has increased since the passage of the Affordable Care Act, renewing interest in the impact of integration between health insurance carriers and acute care hospitals.

Vertical integration does not limit access to health care in Virginia

Most of Virginia's vertically integrated providers operate within limited geographic regions of the state. Eastern Virginia residents have the least choice between vertically integrated providers and other providers. All vertically integrated carriers in Virginia operate in markets where they face competition from other carriers. While Virginians generally have a choice among carriers, vertically integrated carriers have larger proportions of Medicaid and exchange enrollees than other carriers.

The impact of vertical integration on costs to patients, providers, and payers is variable and inconsistent across systems

In theory, vertically integrated systems can generate cost benefits for patients, providers, and carriers through better care management, reduced health care utilization, economies of scale in administration, and lower premiums. However, most stakeholders JCHC staff spoke with said that true savings and total impact on cost can be difficult to quantify. In addition, market dominance, along with a multitude of other factors, interacts with vertical integration to influence cost. Vertically integrated carriers reimburse their affiliated providers differently, though there are no consistent patterns across systems. They also do not report significantly different medical loss ratios from other carriers.

The relationship between vertical integration and quality is mixed

Vertically integrated providers in Virginia have significantly higher quality ratings than other acute care hospitals, and moderately higher patient satisfaction ratings. These findings are in alignment with research that indicates vertically integrated systems perform better than competitors in quality and member satisfaction. Vertically integrated carriers also spend a higher percentage of revenue from member premiums on quality improvement, though their plan quality ratings are not significantly different from those of other health plans.

Legislative Impact

This study was presented for informational purposes only and did not contain any policy options.

Prescription Drug Affordability

Summary

Retail prescription drug spending increases an average of 7.3% annually and state spending on prescription drugs was near $1.9 billion in FY22.

Spending Trends

Total prescription drug spending continues to grow faster than income and inflation. Increased spending impacts out-of-pocket (OOP) costs for consumers. Out of pocket spending has been flat for most consumers, but a minority of consumers face significant financial challenges affording necessary medications.

Inflation Reduction Act (IRA) Provisions

The most significant impact on consumer out of pocket spending will come from the Medicare Part D benefit redesign. Medicare inflation rebates may slow price increases for some drugs for all payers, but the full impact is still unclear. Federal negotiating authority is likely to reduce the Medicare price of some of the highest cost medications.

Pharmacy Benefit Manager (PBM)

States have increasingly regulated PBMs in recent years by way of adding licensing and reporting requirements; auditing standards between PBMs and pharmacies; and setting contract provisions such as gag clauses and spread pricing. This has led to challenges of state laws by the PBM industry, particularly laws that seek to regulate PBMs working with or owned by ERISA plans.

ERISA preemption

The Supreme Court unanimously held in Rutledge v. PCMA that PBM cost-regulations, even if they increase costs or change incentives for plans, are not preempted.

Mulready v. PCMA suggests that (at least in 10th Cir.) pharmacy network restrictions are preempted as a form of interference with benefit design. State laws should apply to PBMs generally, not to the ERISA plans. Any novel attempt at state regulation of ERISA plans or their contracted intermediaries is likely to face a legal challenge but whether the state law will survive the challenge is a separate question.

Legislative Impact

The briefing was presented for informational purposes only and did not contain policy options.

Health Care Workforce

Summary

Virginia has invested in a variety of workforce development programs. Most of the programs focus on workforce recruitment or distribution.

Virginia has invested in a variety of workforce development programs

There are currently a total of 64 health-specific workforce programs and 24 general workforce programs that include health careers in Virginia. Of those, 47 percent receive state funding.

State-funded recruitment and distribution programs target providers and support staff

The Virginia Department of Health receives nearly $5M in state funds annually to administer workforce scholarship or loan repayment programs which include primary care, dental, and behavioral health workforce. The Virginia Community College System receives $34.5M in state funds annually to provide tuition assistance through Virginia's G3 Program. The program assists with obtaining stackable credentials for medical assistants, home health aides, and pharmacy technicians, among others.

Evidence of workforce program effectiveness in Virginia is limited

Based on staff analysis of program data, only 30 percent of Virginia's health care workforce programs collected data on implementation metrics (e.g., numbers of individuals served) and outcomes (e.g., number of credentials earned.) In addition, no Virginia programs had been evaluated for effectiveness, although there are evaluations underway for some programs.

Legislative Impact

The briefing was presented for informational purposes only and did not contain policy options.

Guest Presenters

In addition to hearing JCHC staff reports and briefings, members also received briefings from several guest speakers and stakeholders. Staff from the Department of Medical Assistance Servies (DMAS) and Department of Social Services (DSS) provided a presentation on Medicaid enrollment; DMAS staff and staff from the Department of Aging and Rehabilitative Services (DARS) briefed members on Virginia's brain injury services; members also heard Virginia's Health Information (VHI) annual report; and lastly, staff from Virginia's Department of Health (VDH) briefed on their workgroup report on local health department structure and financing.

Other Staff Activities

JCHC staff participated in several activities related to health policy both in Virginia and nationally. The former Executive Director, Jeff Lunardi, served on the VHI Board of Directors and the Children's Health Insurance Program Advisory Committee (CHIPAC), and served as Vice-Chair on the National Conference of State Legislators (NCSL) Health and Human Services (HHS) Standing Committee. Staff served on the DMAS Hospital Payment Policy Advisory Council (HPPAC) as a Board Member. Staff provided presentation at the Commonwealth Council on Aging Quarterly meeting. Additionally, staff attended the Virginia Department of Health Workgroup meetings on Local Health Department Structure and Financing, and the National Legislative Program Evaluation Society (NLPES) conference. Lastly, staff mentored and supervised one PhD student intern from the University of Virginia, and a COVES Fellow from Virginia Commonwealth University during 2023.

Commission Meetings

The full Commission met six times in 2023:

- May 17th
- August 23rd
- September 20th
- October 18th
- November 13th
- December 6th

The Executive Subcommittee met three times:

- May 17th
- October 2nd (This was a closed meeting to discuss candidates for the Executive Director position)
- October 18th

All meeting materials and minutes are available on the JCHC website (http://jchc.virginia.gov/meetings.asp).

JCHC Direction for 2024 Staff Studies

During the December 2023 meeting, JCHC members identified two priority topics for staff to study during 2024. These two topics align with the JCHC strategic objectives and address pressing issues facing Virginia (Table 1). Study resolutions for each of the studies can be found in Appendix B.

Members also directed staff to develop briefings on three additional topics in 2024. Staff will be assessing the impact of technology on children's health; ways to serve individuals with traumatic brain injury (TBI) in long –term care facilities; and access to health care based on social determinants on health.

Additional studies

During the 2024 Session, four additional topics were referred to the JCHC. At the June 11th meeting, JCHC members voted to add two targeted staff studies to the 2024 workplan.

TABLE 1: 2024 JCHC Study Priorities

	Strategic Objectives Addressed			
Study Topic	**Accessibility**	**Affordability**	**Quality**	**Equity**
Strategies to Extend Health Care Access to Vulnerable Populations	✓	✓	✓	✓
Performance of Health Care Workforce Programs	✓		✓	✓
Sickle Cell Disease in the Commonwealth	✓	✓		✓
Anesthesia Workforce in the Commonwealth	✓		✓	✓

NOTE: The study resolutions were appoved unanimously at the December 6, 2023 JCHC meeting.

Appendix A: JCHC Policy Options and Legislative Action

The following tables show all of the policy options presented in JCHC reports, the action taken by the JCHC members on those policy options, and the legislative action by the full General Assembly.

TABLE 2: Legislative action on policy options for Team-based Care Approaches to Improve Health Outcomes

Policy option	JCHC action	General Assembly action
1. Direct DMAS to establish a reimbursement rate and develop a Collaborative Care Model program.	Adopted as a JCHC recommendation	Budget Item 2888 AAAAA
2. Direct DMAS to establish a reimbursement rate for medication therapy management provided via telehealth.	Adopted as a JCHC recommendation	Not included in final budget
3. Send a letter to JLARC to evaluate state-funded health care workforce incentive programs.	Adopted as a JCHC recommendation	N/A
4. Fund Virginia Task Force on Primary Care to expand pilot programs on core team-based care criteria for payers.	Adopted as a JCHC recommendation	Not included in final budget
5. Fund staff AHECs to support primary care practices transitioning to team-based care.	Adopted as a JCHC recommendation	Not included in final budget
6. Direct DMAS to develop a plan for participation in the Medicaid health home program.	Adopted as a JCHC recommendation	Not included in final budget

NOTE: General Assembly actions occurred during the 2024 legislative session.

TABLE 3: Legislative action on policy options for Obesity and Eating Disorder Prevention and Treatment in Virginia

Policy option	JCHC action	General Assembly action
1. Direct DMAS to develop a plan to incorporate the National Diabetes Prevention Program as a covered service within the Medicaid State Plan	Adopted as a JCHC	Not included in final budget
2. Request HIRC and BOI to define nutritional counseling in the EHB benchmark plan	Adopted as a JCHC recommendation	Budget Item 479 F
3. Request HIRC and BOI conduct assessments to include medical nutrition therapy in the Essential Health Benefits benchmark plan when medically necessary	Adopted as a JCHC recommendation	N/A
4. Direct DMAS to remove service limits for medical nutrition therapy when treating qualifying or eligible medical conditions	Adopted as a JCHC recommendation	Not included in final budget
5. Request HIRC and BOI conduct assessments to include weight loss medication in the Essential Health Benefits benchmark plan when medically necessary, as determined by a healthcare provider	Adopted as a JCHC recommendation	N/A
6. Request HIRC and BOI conduct assessments to include bariatric surgery in the Essential Health Benefits benchmark plan when medically necessary, as determined by a healthcare provider	Adopted as a JCHC recommendation	N/A
7. Direct DMAS to conduct a rate study to develop reimbursement rates for residential, partial hospitalization, and intensive outpatient services for eating disorder services for adults over 21.	Adopted as a JCHC recommendation	Not included in final budget
8. Require all Medicaid MCOs and state-regulated health insurers to remove prior authorization for eating disorder services	Adopted as a JCHC recommendation	Budget Item 479 F

NOTE: General Assembly actions occurred during the 2024 legislative session.

Appendix B: Study resolutions

Study Resolution

Performance of Health Care Workforce Programs Study

Authorized by the Joint Commission on Healthcare on December 6, 2023

WHEREAS, the COVID-19 pandemic exacerbated existing health care workforce shortages in Virginia, and these shortages will persist without additional action; and

WHEREAS, Virginia invests state funds in multiple health care workforce programs to increase recruitment and retention in provider shortage areas; and

WHEREAS, a 2023 Joint Commission on Health Care review indicated that only 30 percent of Virginia's health care workforce programs report metrics on program impact; and

WHEREAS, other public and private entities studying health care workforce programs in Virginia found limited evidence on which to gauge the success of current health care workforce practices, programs, and policies; therefore, be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to monitor and report on the performance and impact of state-funded health care workforce programs.

In conducting its study, staff shall (i) develop a framework for measuring the performance and impact of health care workforce programs; (ii) obtain relevant data from state agencies and other public and private entities collecting data to populate metrics measuring each program's outputs and outcomes; (iii) develop and implement a process for reporting on the performance of programs that is meaningful, transparent, and actionable; and (iv) consider policy options through which the state may improve the performance of state-funded health care workforce programs.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Health, Virginia Department of Health Professions, and the Virginia Department of Medical Assistance Services, shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Study Resolution

Strategies to Extend Health Care Access to Vulnerable Populations

Authorized by the Joint Commission on Healthcare on December 6, 2023

WHEREAS, more than three-quarters of Virginia's localities lack sufficient access to health care services and are federally designated as medically underserved; and

WHEREAS, individuals with limited access to quality health care due to age, geographic location, language spoken, health literacy, chronic illness or disabilities, race or ethnicity, poverty, or gender are vulnerable to poor health outcomes; and

WHEREAS, local health departments and health systems have consistently identified a need to extend health care access directly to the communities where vulnerable populations live to ensure timely care is received before a condition becomes emergent; and

WHEREAS, alternative models for extending health care access to vulnerable populations, including community paramedicine, home visiting, mobile health clinics, telehealth, and use of community health workers, are becoming increasingly common; now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study the impact of models to extend health care access to vulnerable populations in Virginia.

In conducting its study, staff shall (i) evaluate alternative models for extending health care access, including determining which populations benefit from these strategies, how these services are delivered, and how the costs of these services compare to their anticipated benefit; (ii) identify the ways in which peer states support similar alternative models; and (iii) develop policy options through which Virginia may support effective models to extend health care access to vulnerable populations.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Health, the Virginia Department of Social Services, the Virginia Department for Aging and Rehabilitative Services, the Virginia Department of Behavioral Health and Developmental Services, and the Virginia Department of Medical Assistance Services, shall provide assistance, e, information, and data to the Joint Commission on Health Care for this study upon request.

JOINT COMMISSION ON HEALTH CARE

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