JOINT COMMISSION ON HEALTH CARE

2024 INTERIM EXECUTIVE SUMMARY

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #23

COMMONWEALTH OF VIRGINIA
RICHMOND
2025

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

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Vice Chair

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JOINT COMMISSION ON HEALTH CARE

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

January 3, 2025

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

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

Dear Governor Younkin and Members of the General Assembly:

Please find enclosed the interim executive summary of the Joint Commission on Health Care. This report, which summarizes the activities of the Commission in 2024 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 accessed at jchc.virginia.gov.

Respectfully submitted,

Rodney T. Willett, Chair

Interim Executive Summary 2024

The Joint Commission on Health Care (JCHC) was established in 1992 to continue the work of the Commission on Health Care for All Virginians. The JCHC authorizing statute in 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. 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." The Commission undertook the following activities during 2024 to implement this purpose.

Staff Reports and Legislative Recommendations

During 2024, JCHC staff completed four studies as directed by the Commission. At the conclusion of each study, members received a report and presentation from staff and voted on policy options to endorse as JCHC recommendations.

Performance of Health Care Workforce Programs

The JCHC directed staff to monitor and report on the performance and impact of state-funded health care workforce programs. Below is a summary of the findings from this study.

Virginia's General Assembly appropriated $683 million in state funds for 34 health care workforce programs in Fiscal Years 2023 and 2024

The Virginia General Assembly appropriated $318 million for 24 programs exclusively focused on health care workforce, and $365 million for 10 workforce programs partially focused on health care workforce, among other occupational sectors. Ninety percent of state funding supports programs intended to expand the pipeline of health care professionals in secondary, post-secondary, and post-graduate settings. The remaining programs aim to retain health care professionals in Virginia with financial incentives or salary adjustments, or by improving workforce well-being.

State-funded programs are reaching their intended target audience but lack focus on areas of most need

Nearly 80 percent of programs provide services to individuals for whom the program was designed, but programs rarely focus on the health care professional specialties, settings, or geographical areas of highest need in Virginia.

For example, five programs require or prioritize applicants who fulfill service requirements in shortage areas but expanding shortage areas in Virginia are diluting identification of areas of extreme need.

Sparse, inconsistent data collection makes reporting on program quality and impact difficult

Most programs use passive strategies to measure implementation, and track program completion as the main outcome. Nineteen programs have no reporting requirements and only five programs report a positive impact on measured program outcomes, including increased wages, vacancy rates, and retention. With program monitoring responsibilities spread across two entities, programs' barriers to data collection and reporting are not consistently reviewed or addressed.

Members voted to endorse the following policy recommendations:

Option 1 – Send letters to state agencies with fiscal oversight of health care workforce programs requesting a review of program eligibility, screening criteria, and service requirements. This review should identify opportunities to align programs with Virginia's health care workforce needs based on available supply and demand data. Agencies should report to the Joint Commission on Health Care by October 1, 2025, any anticipated changes to program eligibility, screening requirements, and service requirements, or barriers to doing so. Adopted as a JCHC recommendation by a unanimous vote.

Option 2 – (Amended) Submit a Section 1 bill requiring:

1. State agencies with fiscal oversight of health care workforce programs to (i) review of program eligibility, screening criteria, and service requirements, (ii) identify opportunities to align programs with current workforce needs based on available data, and (iii) report to the Joint Commission on Health Care any anticipated changes to program eligibility, screening requirements, and service requirements or barriers to doing so, and
2. The Virginia Health Workforce Development Authority, in collaboration with Virginia Works, to develop a plan to increase capacity for reporting and monitoring of health care workforce programs. The plan should be submitted to the Joint Commission on Health Care by October 1, 2025, and should consider
   (i) Processes required to maintain an accurate inventory of state-funded health care workforce programs;
   (ii) Strategies to increase capacity of state agencies to design, collect, analyze, and report data on program implementation and outcomes, as needed;(iii) Resources needed to increase agency capacity; and(iv) Recommendations to align reporting requirements to meet the program monitoring duties of VHWDA and Virginia

Works while balancing the administrative burden of state agencies to report such information.

Adopted as a JCHC recommendation by a unanimous vote.

Strategies to Extend Health Care Access to Vulnerable Populations

The JCHC directed staff to examine multiple strategies to extend health care access to vulnerable populations. Strategies examined in this study include mobile health clinics, community paramedicine, maternal home visiting, community health workers, and telehealth.

Mobile Health Clinics

Mobile health clinics increase patient access to care by removing costs, distance, and administrative barriers

Mobile health clinics effectively fill gaps in the health care landscape, serving a wide range of vulnerable and underserved populations that lack access to regular health care services. As a flexible health care delivery model, mobile health clinics can tailor the services they provide in response to community needs. By removing cost, distance, and administrative barriers, they may capture patients who may not have sought care otherwise.

Mobile health clinics could be used to expand access to opioid treatment

Patients receiving medication-assisted treatment for opioid use disorder (OUD) require frequent clinic visits for medication management, therapy, and drug screenings. The treatment schedule can be difficult for patients without reliable transportation or accommodating work schedules. There is some evidence that patients who receive OUD treatment medication through mobile programs have similar or improved treatment retention compared to patients at fixed-site clinics. A few treatment centers in Virginia allow patients to get buprenorphine prescriptions at their mobile health clinics. The Department of Behavioral Health and Developmental Services has received federal approval for mobile methadone clinics and plans to begin operations in the future.

Logistical challenges, staffing shortages, and lack of reliable funding make mobile health clinic operations difficult

The small, contained nature of mobile health clinics is a strength for taking health care where it is needed, but presents its own set of challenges. Staff must manage vehicle maintenance, weather, parking, and safety considerations that affect operations. Additionally, the kinds of services mobile health clinics can offer is highly dependent on vehicle size, staffing, funding, and the availability of broadband. Addressing internet deployment and adoption gaps would help mobile health clinics facilitate telehealth and expand access to services, particularly in rural areas.

Members voted to endorse the following policy recommendations for mobile health clinics:

Option 1 – Introduce legislation directing the Board of Pharmacy to work with the Department of Behavioral Health and Developmental Services to develop a process by which opioid treatment programs can apply for and receive necessary permissions and waivers to allow dispensing of opioid use disorder treatment medications from mobile units. The Board would report on the status of the process and any barriers to developing and implementing such process to the Joint Commission on Health Care by November 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 2 – (Amended) Introduce legislation directing the Department of Housing and Community Development (DHCD) to include broadband access services for mobile health clinics as a priority for broadband adoption programs using Broadband Equity, Access, and Deployment Program funding, as part of DHCD's broader initiative to support other telehealth adoption programs; and require DHCD to report to the Joint Commission on Health Care regarding current gaps in broad. Adopted as a JCHC recommendation by a unanimous vote.

Option 3 – (Amended) Introduce a budget amendment to provide $1 million to the Virginia Health Care Foundation to provide grants to public agencies or nonprofit organizations to support mobile health clinics to improve access to health care for uninsured individuals and individuals with limited access to health care. Adopted as a JCHC recommendation by a unanimous vote at the December 17th meeting.

Community Paramedicine

Community paramedicine and mobile integrated healthcare utilize emergency medical services (EMS) providers in new roles

EMS providers are increasingly being utilized in non-traditional roles and settings to provide public health, primary health care, and preventive services.

- Community paramedicine programs use paramedics.
- Mobile integrated healthcare programs use multi-disciplinary care teams, which may include emergency medical technicians and paramedics.

Community paramedicine extends patient access to care and relieves pressure from emergency systems

Community paramedicine programs usually serve high-risk or high-needs individuals who frequently call 911, have complex medical needs, or are at risk of hospitalization. Program participants may receive preventive care, primary care, and linkages to psychosocial supports. Community paramedicine programs effectively reduce unnecessary emergency

call volume, ambulance transports, emergency department visits, readmission rates, and inpatient utilization. This leads to better outcomes for patients while also reducing medically unnecessary EMS calls and transports.

Funding and capacity are the largest program limiters

In Virginia, community paramedicine programs have few reimbursement opportunities. Programs do not charge participants and rarely can bill health insurance for their services. Lack of consistent funding makes it difficult for smaller or more rural EMS agencies to develop the capacity to expand their services to include community paramedicine. Medicaid is the most frequent payer for community paramedicine services, and states have flexibility to determine whether and how they will reimburse for services. Providing reimbursement through the state's Medicaid program and tapping into additional federal funding opportunities may support general capacity building for EMS agencies and development of community paramedicine programs.

Members voted to endorse the following policy recommendations for Community Paramedicine:

Option 4 – (Amended) Introduce legislation directing the Virginia Department of Health's Office of Emergency Medical Services (OEMS) to report to the Joint Commission on Health Care by October 1, 2025, regarding the status of draft regulations related to community paramedicine and mobile integrated healthcare. As part of its update, OEMS should also report on the feasibility of integrating telehealth services into the delivery of emergency medical services provided by emergency medical services providers at the scene of an emergency. Adopted as a JCHC recommendation by a unanimous vote.

Option 5 – (Amended) Introduce a budget amendment to provide $1.8 million to the Virginia Department of Health to establish a pilot program administered by Office of Emergency Medical Services to provide funding to local governments to establish community paramedicine and mobile integrated healthcare programs. Adopted as a JCHC recommendation by a unanimous vote.

Option 6 – Introduce legislation directing the Department of Medical Assistance Services to cover HCPCS Code A0998 treatment without transport when Medicaid patients call 911. Adopted as a JCHC recommendation by a 14-0-1 vote at the December 17th meeting.

Option 7 – Introduce legislation directing the Department of Medical Assistance Services to work with the Virginia Department of Health's Office of Emergency Medical Services to develop a plan for reimbursing community paramedicine and mobile integrated healthcare services in Virginia, in consultation with community paramedicine programs and other stakeholders including hospital systems and health plans. The plan should specify the circumstances under which services would be covered; eligible patient populations; eligible providers; whether the model would require a State Plan Amendment or modification of managed care contracts; and whether reimbursement would be a flat fee or allow billing for

individual services. The Department of Medical Assistance Services would report to the Joint Commission on Health Care by October 1, 2025, regarding the content of the plan. Adopted as a JCHC recommendation by a unanimous vote.

Option 8 – Introduce legislation directing the Department of Medical Assistance Services to seek approval from the Centers for Medicare and Medicaid Services for implementation of the Ground Emergency Medical Transportation program in Virginia, to allow emergency medical services providers in Virginia to receive supplemental reimbursement for uncompensated costs related to the transfer of Medicaid patients. Adopted as a JCHC recommendation by a unanimous vote.

Home Visiting

Home visiting programs are supported through a combination of funding streams

The capacity and sustainability of home visiting programs in Virginia is directly related to available funding and resources directed towards these efforts. In Virginia, as in other states, home visiting programs are supported by a mix of federal, state, local, and private funds. In FY 2024, overall investment in local home visiting services in Virginia totaled $36 million. The Maternal, Infant, and Early Childhood Home Visiting Program is the largest source of federal funding. There are certain requirements that need to be met to be eligible for federal funding. If more of Virginia's home visiting programs meet these requirements, it is possible more of this funding could be extended to other home visiting models.

Virginia could leverage Medicaid funding to enhance capacity of home visiting services

Since there is no single service under the Medicaid program defined as home visiting, federal guidance gives states the option to create state plan amendments under several other state plan benefit categories that cover services provided through home visiting programs. At least 28 states offered a home visiting benefit through their state Medicaid programs, most of which do through a Medicaid state plan amendment.

Members voted to endorse the following policy recommendations for Home Visiting:

Option 9 – Introduce a budget amendment to provide $4,541,671 to Families Forward Virginia to serve a new cohort of parents that will be part of a randomized control trial required to collect evidence to be submitted to the federal Department of Health and Human Services to determine whether CHIP of Virginia meets criteria for certification as an evidence-based home visiting model consistent with the Department's Home Visiting Evidence of Effectiveness criteria. Adopted as a JCHC recommendation by a 11-1-0 vote.

Option 10 – Introduce legislation directing the Department of Medical Assistance Services (DMAS), in conjunction with relevant stakeholders, to convene a workgroup to develop a plan for a home visiting benefit for pregnant and postpartum individuals and their families. The workgroup shall develop consensus with stakeholders and make recommendations in the plan regarding the design of various program elements including service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation requirements, to guide any future cost impact analysis for the proposed home visiting benefit that may be required. DMAS would report to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1st, 2025, regarding the plan for the design of a home visiting benefit and any next steps which shall be necessary for federal approval and implementation of the home visiting benefit. Adopted as a JCHC recommendation by a unanimous vote.

Community Health Workers

Virginia has taken steps to expand access to services provided by community health workers (CHWs), but insufficient funding continues to be a barrier

During the 2024 Session, the General Assembly appropriated $3.2 million per year in FY 2025 and FY 2026 to support CHW positions at local health districts but did not fund the full $5.2 million amount requested by the Virginia Department of Health (VDH). Appropriating additional general funds to VDH to cover the full cost of supporting CHW positions at local health departments could ensure that CHWs remain available to provide necessary services in their communities. A more comprehensive review could allow VDH to determine the need for and capacity of state and local health departments to support CHWs and could help VDH better determine the funding needs of state and local health department CHW programs on an ongoing basis.

Access to CHW services could be expanded by leveraging Virginia's Medicaid program as a sustainable funding mechanism

At least 24 states offer Medicaid reimbursement for CHW services, either through a Medicaid state plan amendment or contracts with managed care organizations. Virginia could implement either option to leverage Medicaid reimbursement for the services CHWs provide. Virginia could also provide reimbursement for services provided by CHWs by developing opportunities for CHWs to become eligible for reimbursement for other services already reimbursed by the state's Medicaid program.

CHWs need ongoing workforce development opportunities to avoid burnout and support retention

Providing state support to a CHW professional organization can help ensure there is access to mentorship, advocacy, and training opportunities to engage the CHW workforce.

Members voted to endorse the following policy recommendations for Community Health Workers:

Option 11 – (Amended) Introduce a budget amendment to provide an additional $2.5 million to the Virginia Department of Health (VDH) in Fiscal Year 2026 to support all remaining community health worker (CHW) positions initially supported by federal funding and remove language requiring VDH to prioritize CHW positions in high maternal mortality areas to allow flexibility of localities to develop and implement CHW-led programs that address community needs. Require VDH to report on use of funds provided in previous years. Adopted as a JCHC recommendation by a unanimous vote.

Option 12 – (Amended) Introduce legislation directing the Virginia Department of Health to report annually, by November 1, to the Chairs of the House Committee on Appropriations and Senate Committee on Finance and Appropriations and the Director of Department of Planning and Budget regarding the numbers of community health workers (CHWs) employed within state and local health departments, the type of services provided by CHWs and performance and outcome measures for such services, the need for additional CHWs to meet demand for services provided by state and local health departments, any success in attracting non-state resources, and descriptions of the contracts entered by localities. Adopted as a JCHC recommendation by a unanimous vote.

Option 13 – (Amended) Introduce legislation directing the Department of Medical Assistance Services (DMAS) to convene a work group of stakeholders to design a state plan amendment (SPA) to provide reimbursement for services provided by Certified Community Health Workers (CCHWs). The plan shall include service definitions, administrative structure, eligibility criteria, provider participation requirements, population prevalence, service setting options, and federal evaluation requirements. DMAS shall report to the Joint Commission on Health Care and the Chairs of the House Committee on Appropriations and Senate Committee on Finance and Appropriations regarding the plan for a SPA to provide reimbursement for services provided by CCHWs

and any next steps necessary for federal approval and implementation of the SPA by October 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 14 – (Combined with option 13) Introduce legislation directing the Department of Medical Assistance Services to convene a workgroup to identify opportunities to expand use of community health workers by Medicaid managed care organizations. Adopted as a JCHC recommendation by a unanimous vote.

Option 15 – (Combined with option 13) Introduce legislation directing the Virginia Department of Health (VDH) to convene a work group composed of representatives of the Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), and other relevant stakeholders to determine the feasibility of developing flexible training and certification standards that allow community health workers (CHWs) to use their education and experience to satisfy some of the requirements for qualification as a state-certified doula or registered peer recovery specialist. The workgroup would report on activities to the Joint Commission on Health Care and the chairs of the Senate Committee on Education and Health and House Committee on Health and Human Services by October 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 16 – Introduce a budget amendment to provide $250,000 annually to the Virginia Community Health Worker Association (VACHWA) to, in partnership with relevant stakeholders, expand workforce development efforts for community health workers. The VCHWA would report to the Joint Commission on Health Care and the Chairs of the Senate Committee on Education and Health and the House Committee on Health and Human Services by October 1, 2025, regarding plans for the use of such funding. Adopted as a JCHC recommendation by a unanimous vote.

Telehealth

Telehealth improves access to health care for vulnerable and underserved populations

Telehealth can improve patient access to care by removing transportation-related barriers, increasing access to culturally appropriate care, improving efficiency of healthcare practices, and mitigating the effects of workforce shortage.

Inadequate coordination of telehealth initiatives, lack of training and guidance for providers creates challenges

Lack of dedicated staff at VDH has resulted in a failure to maintain progress on the Telehealth State Plan and lack of provider education on telehealth. Providers in Virginia require training around Medicaid coverage, telehealth best practices, and delivery of telehealth to individuals with disabilities.

Limited access to broadband and telehealth technology restricts patients' access to telehealth services

Telehealth Access Points (TAPs) are pre-existing community spaces that have the technology and internet infrastructure necessary to support telehealth services. TAPs could increase access to telehealth services for patients in areas where broadband access is an issue.

Gaps in coverage and insufficient reimbursement for telehealth are barriers to telehealth implementation

Low reimbursement rates and lack of coverage for some telehealth services disincentivize providers from offering telehealth services because they are receiving less compensation for what they view as the same amount of patient care.

Lack of resources to expand the capacity of programs that provide telehealth access limits access to services

Telehealth programs often lack adequate resources to meet demand for program services. Providing or increasing funding for telehealth programs would expand access to health care services for vulnerable and underserved patients.

Members voted to endorse the following policy recommendations for Telehealth:

Option 17 – Introduce a budget amendment to provide $127,224 to the Virginia Department of Health to cover the cost of salary and benefits for a new Telehealth Coordinator position at the Virginia Department of Health. Adopted as a JCHC recommendation by a unanimous vote.

Option 18 – Introduce legislation directing the Department of Behavioral Health and Developmental Services to work with relevant state agencies and stakeholders to develop and disseminate best practice educational training for providers on how to conduct telehealth visits for patients with disabilities, including individuals with intellectual and developmental disabilities. Adopted as a JCHC recommendation by a unanimous vote.

Option 19 – Introduce a budget amendment to provide $150,000 to the Virginia Telehealth Network (VTN) to conduct a feasibility study and develop a plan to implement a pilot program to provide funding for Pharmacy Care Hubs, particularly for Medicaid patients. The VTN would report to the Joint Commission on Health Care by November 1, 2026, regarding the results of the feasibility study and the plan to

implement additional Pharmacy Care Hubs in Virginia. Adopted as a JCHC recommendation by a unanimous vote.

Option 20 – (Amended) Introduce legislation directing the Virginia Board of Education to require local boards of education to consider policies to facilitate students' access to telehealth services during the school day, which may include designating private spaces for appointments to occur. Adopted as a JCHC recommendation by a unanimous vote.

Option 21 – (Revised) Introduce a budget amendment authorizing the Department of Medical Assistance Services to provide reimbursement for provider-to-provider consultations delivered through telehealth, consistent with the state plan and in a manner that is budget neutral and does not increase costs. The Department shall promulgate emergency regulations to implement this change. Adopted as a JCHC recommendation by a unanimous vote.

Option 22 – Introduce legislation directing the Department of Medical Assistance Services to develop a plan and estimate costs for expanding eligibility criteria under Medicaid for remote patient monitoring for individuals with chronic conditions and to report to the Joint Commission on Health Care by October 1, 2025, regarding such plan and estimated costs. Adopted as a JCHC recommendation by a unanimous vote.

Option 23 – Introduce legislation removing the exclusion of audio-only telephonic communication from the definition of telemedicine and requiring insurers to cover audio-only telephone telehealth visits to the same extent that they cover other types of telemedicine services in cases in which audio-only telephone telehealth services are clinically appropriate, provided consistent with the same standard of care as is applicable to comparable in-person services, and utilized only in cases in which other forms of telehealth are not available or cannot be accessed by the patient. Adopted as a JCHC recommendation by a unanimous vote.

Option 24 – Introduce a budget amendment to increase funding for the Virginia Telemental Health Initiative by $482,000 to support increasing patients served by 50 percent. Adopted as a JCHC recommendation by a unanimous vote.

Option 25 – Introduce a budget amendment to provide $178,503 to Virginia Health Catalyst to, in collaboration with the Oral Health Task Force, plan and implement a one year pilot program, through Federal Qualified Health Centers and local community health centers, in which dental hygienists deliver teledentistry services in three nursing homes. Adopted as a JCHC recommendation by a unanimous vote.

Option 26 – (Amended) Introduce legislation requiring the Department of Corrections (VADOC) and the Virginia Board of Local and Regional Jails to establish policies to accommodate inmates needing to participate in telehealth appointments, including designating a private space for such appointments to occur. VADOC and the Virginia Board of Local and Regional Jails should provide an update to the JCHC by October 1, 2025, on the current status of telehealth policies, opportunities to expand telehealth programs, and recommended strategies to reduce gaps or barriers to telehealth service delivery. Adopted as a JCHC recommendation by a unanimous vote.

Expanding Access to Sickle Cell Disease Treatment in Virginia

The JCHC directed staff to conduct a narrowly scoped study of sickle cell disease in the Commonwealth.

VDH identifies and monitors cases of sickle cell disease in Virginia and is improving surveillance through a statewide registry

VDH programs effectively identify potential cases of sickle cell disease at birth, facilitate diagnostic testing and entry into care, and provide education and counseling for individuals with sickle cell disease and their families. Recent legislation addresses additional gaps in disease surveillance by requiring VDH to establish a statewide sickle cell disease registry.

Sickle cell disease treatment centers provide access to specialized sickle cell disease care but lack capacity for needed treatment and support services

Most treatment centers receive state funding to cover a portion of the cost of providing support services for patients with sickle cell disease. State funds do not cover the full cost of these services nor the costs of treatment. Additional information is needed to understand the resources required to address unmet need at treatment centers.

Providers' lack of knowledge about sickle cell disease and bias about individuals with sickle cell disease can delay appropriate care

Emergency department providers may be unfamiliar with how to care for sickle cell disease patients, feel uncomfortable prescribing opioids, or perceive adults with sickle cell disease to have increased risk of substance abuse, despite evidence to the contrary. Delayed treatment may cause worse outcomes than if treatment were initiated in a timely manner.

Addressing cost and insurance barriers could improve treatment access for individuals with sickle cell disease

Patients with sickle cell disease may delay or avoid care, or discontinue treatment or medications, due to costs. Stakeholders also reported difficulties with insurers'

utilization management processes, particularly when seeking approval for opioids and disease-modifying therapies. While Medicaid covers an array of services for eligible individuals with sickle cell disease, opportunities may exist to expand coverage and improve standardization of care across managed care organizations.

Members voted to endorse the following policy recommendations:

Option 1 – Write a letter to request that the Virginia Department of Health provide an update, by September 1, 2025, on the plan for and status of the statewide sickle cell disease registry, including information about the types of data that will be collected, how the data will be used, and who will be able to access the data. Adopted as a JCHC recommendation by a unanimous vote.

Option 2 – (Amended to include option 3) Introduce a budget amendment to provide funds to the Virginia Department of Health (VDH) to conduct a needs assessment to determine the extent of the need for treatment, transition, and mental health and other psychosocial support services for patients receiving services at comprehensive sickle cell treatment centers participating in the Pediatric and Adult Comprehensive Sickle Cell Clinic Networks, and to develop a plan for and an estimate of the cost of addressing such need to meet the needs of current patients and provide necessary services to new patients. VDH should report the results of the needs assessment and the plan and cost estimate to the Chairmen of House Committee on Appropriations, Senate Committee on Finance and Appropriations, and Joint Commission on Health Care by October 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 3 – (Incorporated into option 2) Introduce a budget amendment to provide funds to the Virginia Department of Health (VDH) to conduct a needs assessment to determine the extent of need for transportation services for patient receiving services at comprehensive sickle cell treatment centers participating in the Pediatric and Adult Comprehensive Sickle Cell Clinic Networks and to develop a plan for and an estimate of the cost of addressing such need. VDH should report the results of the needs assessment and the plan and cost estimate to the Chairmen of House Committee on Appropriations, Senate Committee on Finance and Appropriations, and the Joint Commission on Health Care by October 1, 2025.

Option 4 – Introduce a Section 1 bill directing the Virginia Department of Health (VDH) to develop a plan to ensure health care providers in hospital emergency departments have access to information about individuals with sickle cell disease to confirm patients' sickle cell status and facilitate timely and appropriate access to care. In developing such plan, VDH shall (i) consider alternative models for providing access to information about sickle cell disease for health care providers in emergency departments including determining whether the statewide sickle cell registry or other

existing programs could be expanded to serve such purpose and (ii) identify any statutory or budgetary changes necessary to implement such plan. VDH shall report to the Joint Commission on Health Care regarding the plan by October 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 5 – Introduce legislation directing the Boards of Medicine and Nursing to require unconscious bias and cultural competency training as part of the continuing education and continuing competency requirements for renewal of licensure. Adopted as a JCHC recommendation by a 14-1-1 vote.

Option 6 – Introduce a Section 1 bill directing the Department of Medical Assistance Services to include information on the status of the Commonwealth's participation in the Cell and Gene Therapy Access Model in the annual report on the results of the annual review of all medications, services, and forms of treatment for sickle cell disease covered under the state plan for medical assistance submitted to the Chairs of the House Committee on Health and Human Services, Senate Committee on Education and Health, and the Joint Commission on Health Care by November 15, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 7 – Introduce a Section 1 bill directing the Department of Medical Assistance Services (DMAS) to develop a plan for a comprehensive sickle cell disease program to ensure that provisions governing access to sickle cell disease treatment are consistent across Medicaid managed care organizations. DMAS should report the results of the plan to the Joint Commission on Health Care by October 1, 2025. Adopted as a JCHC recommendation by a unanimous vote.

Option 8 – Introduce a Section 1 bill directing the Department of Medical Assistance Services (DMAS) to determine the feasibility of participating in an optional Medicaid benefit for sickle cell disease or establishing Medicaid Health Homes to coordinate care for individuals with sickle cell disease to provide comprehensive sickle cell treatment services. DMAS should report their findings in the annual report on the results of the annual review of all medications, services, and forms of treatment for sickle cell disease covered under the state plan for medical assistance submitted to the Chairs of the House Committee on Health and Human Services, Senate Committee on Education and Health, and the Joint Commission on Health Care by November 15, 2025**.** Adopted as a JCHC recommendation by a unanimous vote.

Strategies to Strengthen the Anesthesia Workforce in Virginia

JCHC members directed staff to conduct a targeted, narrowly scoped study on the anesthesia workforce in Virginia.

Multiple authorities are responsible for determining supervision requirements of certified registered nurse anesthetists

There are at least three layers of rules that may impact the extent to which certified registered nurse anesthetists (CRNAs) are supervised, including federal rules, state laws, and hospital or facility bylaws. Due to the interplay between these overlapping authorities, CRNA supervision requirements vary widely in each state. In Virginia, CRNAs are currently subject to the federal rule and Code of Virginia § 54.1-2957.

Stakeholders agree that more restrictive supervision requirements would be detrimental to efforts to address anesthesia workforce shortages

Stakeholders agreed that implementing more restrictive supervision requirements for CRNAs would greatly impact how anesthesia care is delivered in Virginia, particularly for remote or rural facilities in Virginia which use proceduralists as CRNA supervisors and may not have physician anesthesiologists on staff.

Available evidence supports a measured approach to changes in CRNA supervision requirements

Evidence indicates that less restrictive CRNA supervision requirements present a low risk of harm to patients and a possible benefit to the anesthesia workforce. State models that step down from supervision into independent practice could be considered so that possible impacts can be monitored over time.

Strengthening Virginia's anesthesia workforce requires a multifaceted approach

Stakeholders interviewed by the JCHC offered alternative strategies to address anesthesia provider workforce shortages beyond changes to CRNA supervision, including the licensing of Certified Anesthesiologist Assistants to practice in Virginia and developing additional capacity for physician anesthesiologist residency programs and CRNA training programs.

Members voted to endorse the following policy recommendations:

Option 2 – Not recommend any policy that would make supervision of certified registered nurse anesthetists more restrictive than current state statute or federal rule require. Adopted as a JCHC recommendation by a unanimous vote.

Option 4 – (Amended) Introduce legislation providing for the licensing of Certified Anesthesia Assistants in the Commonwealth. Adopted as a JCHC recommendation by a unanimous vote.

Option 5 – Submit a budget amendment, providing funding to the Virginia Health Workforce Development Authority (VHWDA) to, in collaboration with the State Council of Higher Education for Virginia, and other relevant stakeholders, study the capacity and needs of current anesthesiology residency programs and certified registered nurse anesthetist training programs in Virginia and make recommendations for further expansion. VHWDA would submit a report to the Joint Commission on Health Care and to the Chairs of the House Committee on Appropriations Committee and Senate Committee on Finance and Appropriations by October 1, 2026. Adopted as a JCHC recommendation by a unanimous vote.

Stakeholder briefings

During the July meeting, Dr. Koeun Choi from Virgina Tech University presented on the impact of technology on children's health. She discussed the statistics on usage time by children and the benefits and risks of screen time and media usage as well as the role parents play in technology effects on children.

During the September meeting, Virginia Center for Health Innovation staff presented an update on the Virgina Task force on Primary Care. They spoke about tasks that the agency is accomplishing including primary care pilots as well as figures for healthcare spending, and the decline in primary care usage. Lastly, they discussed some recommendations that will require legislative action.

Commissioner Nelson Smith from the Department of Behavioral Health and Developmental Services briefed members on the proposed closure of the Hiram Davis Medical Center (HDMC). He provided a brief history of the center and an overview of the building's deficiencies as well as information about the costs of renovating vs. building a new facility. He described the process that would be followed to make a final decision on the future of HDMC, and the statutory timeline that must be observed.

Commission Meetings

The full JCHC met seven times this year, and the Executive Subcommittee met two times. Below is a list of all JCHC meeting dates. All meeting materials and minutes are available on the JCHC website (http://jchc.virginia.gov/meetings.asp).

Full Commission

- May 22nd
- June 11th
- July 17th

- September 18th
- October 23rd
- November 26th
- December 17th

Executive Subcommittee

- June 11th
- October 23rd

Other Staff Activities

JCHC staff participated in several activities related to health policy both in Virginia and nationally. The Executive Director participated as a member of the Children's Health Insurance Program Advisory Committee (CHIPAC) and Department of Medical Assistance Services' Hospital Payment Policy Advisory Council (HPPAC), supported the House Select Committee on Advancing Rural and Small Town Health Care, presented on a panel at the Virginia Quality Healthcare Network's (VQHN) Breakfast with the Experts, and participated as a guest lecturer on public policy matters for graduate courses at the University of Virginia and Virginia Commonwealth University. The Deputy Director presented on a panel at the AcademyHealth annual research meeting on policymakers' perspectives on research and guest lectured on public policy during a PhD seminar course at Virginia Commonwealth University. Additionally, staff attended the Academy Health conference, National Conference of State Legislatures Annual Meeting, and National Association of State Health Policy annual conference. Lastly, staff mentored and supervised one PhD COVES Fellow from the University of Virginia.

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