JOINT COMMISSION ON HEALTH CARE

2024 ANNUAL REPORT

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #298

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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The Honorable Delegate Rodney T. Willett

Vice Chair

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JOINT COMMISSION ON HEALTH CARE

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

June 12, 2025

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
201 N Ninth Street
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 2024 and legislative action taken by the Commission during the 2025 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 2024 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 provides that the purpose of the JCHC is "to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services" (§ 30-168). In 2020, the JCHC adopted four strategic objectives, drawn from the Commission's authorizing legislation, to guide the work of the Commission: accessibility, affordability, quality, and equity. The JCHC works to achieve its statutory purpose and further its strategic objectives by studying relevant health policy questions, receiving presentations on relevant health policy topics from JCHC staff and key stakeholders, and adopting policy recommendations for legislative action to address health policy issues.

The JCHC is comprised of 18 legislative members –eight members of the Senate appointed by the Senate Committee on Rules and ten members of the House of Delegates appointed by the Speaker of the House. The Secretary of Health and Human Resources is an ex officio member of the JCHC. Delegate Rodney Willett served as Chair and Senator Ghazala Hashmi served as the Vice Chair in 2024.

2024 Staff Reports

In 2024, JCHC staff completed and provided final reports and briefings on four topics:

- Performance of Health Care Workforce Programs
- Strategies to Extend Health Care Access to Vulnerable Populations
- Expanding Access to Sickle Cell Disease Treatment in Virginia
- Strategies to Strengthen the Anesthesia Workforce in Virginia

Performance of Health Care Workforce Programs

Report Summary

The Commonwealth of Virginia, consistent with national trends, is facing a historic challenge with ongoing health care workforce shortages. The COVID-19 pandemic exacerbated pre-pandemic health care workforce concerns, with already critical shortage areas being hit the hardest. As of July 2024, all 133 localities in Virginia are federally

designated as behavioral health shortage areas, 98 localities are federally designated as dental health shortage areas, and 96 localities are designated as primary care shortage areas. Strains to provide services and attract and retain health care workers have been reported across almost every health care profession.

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.

Legislative Impact

This study included two policy options, both of which were adopted by the JCHC as policy recommendations.

One policy recommendation resulted in letters to state agencies with fiscal oversight of health care workforce programs requesting that such agencies review eligibility criteria, screening criteria, and service requirements for such programs to identify opportunities to align programs with Virginia's health care workforce needs, as indicated by available supply and demand data, and report to the JCHC by October 1, 2025, regarding any anticipated changes to such eligibility criteria, screening criteria, and service requirements, or barriers to making such changes.

No legislation implementing the second policy option was introduced during the General Assembly Session.

(See Appendix A, Table 1 for a full listing of all policy options and legislative outcomes for this study.)

Strategies to Extend Health Care Access to Vulnerable Populations

Report Summary

Access to care is a critical marker of effective health care systems and is broadly defined as obtaining appropriate health care services when needed. Access to care considers opportunities and barriers to identifying health care needs, seeking health care services, using health care services, and having the need for those services fulfilled. Access to care is influenced by social determinants of health (SDOH), defined as the nonmedical factors, such as the conditions in which people are born, grow, work, live, and age, that influence health outcomes. Community variations in SDOH impact access to care, so that certain populations, nationally and in Virginia, have worse access to care than other populations. These gaps in access can lead to differences in health outcomes and, ultimately, life expectancy.

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 medication-assisted treatment for OUD through mobile programs have similar or improved treatment retention compared to patients at fixed-site 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 are 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.

Community Paramedicine

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

Emergency medical services (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 operating in expanded roles to assist with public health and primary health care. Mobile integrated healthcare programs use multi-disciplinary care teams, which may include emergency medical technicians and paramedics, to provide health care services.

Community paramedicine extends patient access to care and relieve 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
Medicaid is the most frequent payer for community paramedicine services nationally, and states have flexibility to design how they will cover these services. In Virginia, community paramedicine programs have few reimbursement opportunities. Programs do not charge participants and rarely can bill health insurance for their services. This makes it difficult for smaller or more rural EMS agencies who do not have the capacity to expand their services to community paramedicine. Reimbursing for community paramedicine would support sustainability, and tapping into additional federal funding may support general capacity building for EMS agencies.

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. To be eligible for federal funding, programs must meet specific requirements. Increasing the number of home visiting programs in Virginia that meet federal requirements could increase the amount of funding available to support home visiting services in the state.

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.

Community Health Workers

Virginia has taken steps to expand access to services provided by community health workers, 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 community health worker (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.

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.

Legislative Impact

This study included 26 policy options. Three options were combined into a single policy option by the JCHC. All of the resulting 24 policy options were adopted by the JCHC as policy recommendations.

Nine bills implementing eight policy recommendations resulting from this study were introduced during the 2025 Session of the General Assembly. Seven bills were enacted by the General Assembly, and two bills were not enacted.

Nine budget amendments implementing policy recommendations resulting from this study were introduced during the 2025 Session of the General Assembly, but none were included in the final 2025 Appropriation Act.

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

Expanding Access to Sickle Cell Disease Treatment in Virginia

Report Summary

Sickle cell disease (SCD) is a severe inherited blood disorder that predominantly impacts people of color, particularly African Americans. Individuals living with SCD can encounter barriers to obtaining quality care such as limited geographic access, financial and socioeconomic barriers, specialist availability, transportation needs, social factors, and lack of public awareness. New available treatments can increase life expectancy and improve quality of life; however, there is a need for more comprehensive coordinated data collection efforts to better understand the impact of SCD and ensure there is access to sickle cell disease treatment.

The Virginia Department of Health identifies and monitors cases of SCD in Virginia and is improving surveillance through a statewide registry

The Virginia Department of Health (VDH) effectively identifies potential cases of SCD at birth, facilitates diagnostic testing and entry into care, and provides education and counseling for individuals with SCD and their families. Recent legislation addresses additional gaps in disease surveillance by requiring VDH to establish a statewide sickle cell disease registry.

SCD treatment centers provide access to specialized SCD 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 SCD. 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 SCD and bias about individuals with SCD can delay appropriate care

Emergency department providers may be unfamiliar with how to care for SCD patients, feel uncomfortable prescribing opioids, or perceive adults with SCD 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 SCD

Patients with SCD 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.

Legislative Impact

This study included eight policy options. Two policy options were combined by the JCHC, resulting in seven policy options. All seven policy options were adopted by the JCHC as policy recommendations.

One policy recommendation resulted in a letter to VDH requesting an update on the plan for and status of the statewide sickle cell disease registry.

Legislation implementing two policy recommendations resulting from this study was introduced during the 2025 Session of the General Assembly. One bill was not adopted by the General Assembly and the other bill was vetoed by the Governor.

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

Strategies to Strengthen the Anesthesia Workforce in Virginia

Summary

Anesthesia is an important aspect of patient care and prevents patients from feeling pain during surgery or other medical procedures. There are three types of health care

professionals who can deliver anesthesia care, two of which practice in Virginia. A physician anesthesiologist is a doctor of medicine or osteopathy who administers anesthesia. A certified registered nurse anesthetist (CRNA) is an advanced practice registered nurse who specializes in administering anesthesia. Certified anesthesiologist assistants (CAAs) practice as members of care teams who work under the direction of a physician anesthesiologist to carry out the anesthesia care plan. CAAs are not permitted to practice in Virginia but do practice in 21 other states/localities. Each provider has differing levels of education, training, and responsibilities as it pertains to a patient's anesthesia care.

Multiple authorities are responsible for determining supervision requirements of CRNAs
There are at least three layers of rules that may impact the extent to which 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 CAAs to practice in Virginia and developing additional capacity for physician anesthesiologist residency programs and CRNA training programs.

Legislative Impact

This study included five policy options. Two policy options were not adopted by the JCHC and three policy options were adopted as policy recommendations.

Two bills implementing one policy recommendation resulting from this study were introduced during the 2025 Session of the General Assembly. One bill was enacted by the General Assembly and one bill was not adopted by the General Assembly.

One budget amendment implementing a policy recommendation resulting from this study was introduced during the 2025 Session of the General Assembly, but the budget amendment was not included in the final 2025 Appropriate Act.

(See Appendix A, Table 4 for a full listing of all policy options and legislative outcomes for this study.)

Staff Informational Briefings

JCHC staff provided two informational briefings in 2024:

- Impact of Technology on Children's Health
- Brain Injury Services

The informational briefing on the Impact of Technology on Children's Health included presentations by Dr. Keoun Choi, Assistant Professor, Department of Human Development and Family Science, and Director, Cognitive Developmental Science Lab, Virginia Polytechnic University, and Heather Morton, Director, Financial Services, Technology, and Communications & Flora Fouladi, Health Policy Associate, National Conference of State Legislatures,

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 during 2024.

Commission Meetings

The full JCHC met seven times this year, and the Executive Subcommittee met two times.

Full Commission

- May 22nd
- June 11th
- July 17th
- September 18th
- October 23rd
- November 26th
- December 17th

Executive Subcommittee

- June 11th
- October 23rd

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

2025 Staff Studies

During the December 2024 meeting, JCHC members selected three comprehensive staff studies to be completed in 2025:

- Policy Solutions to the Commonwealth's Fentanyl Crisis;
- Access to Pharmacy Services; and
- Strategies to Address Transportation-Related Barriers to Health Care.

These three studies align with the JCHC strategic objectives and address pressing issues facing Virginia. Study resolutions for each of the studies can be found in Appendix B.

At the May 2025 meeting, JCHC members selected two additional targeted staff studies to be completed in 2025:

- Legislative Options for Oversight of Medicaid Program Spending; and
- Implementation of a Medicaid In Lieu of Services Food and Nutrition Benefit.

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 1: Legislative action on policy options for performance of health care workforce programs

Policy option	JCHC action	General Assembly action
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.	Adopted as a JCHC recommendation	N/A
2. Introduce a Section 1 bill requiring 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.	Adopted as a JCHC recommendation	Not introduced

NOTE: General Assembly actions occurred during the 2025 legislative session.

TABLE 2: Legislative action on policy options for strategies to extend health care access to vulnerable populations

Policy option	JCHC action	General Assembly action
1. Direct the Board of Pharmacy to work with the Department of Behavioral Health and Developmental Services to develop a process to allow dispensing of opioid use disorder treatment medications from mobile units.	Adopted as a JCHC recommendation	SB841 Failed to pass
2. Direct the Department of Housing and Community Development to include broadband access services for mobile health clinics as a priority for broadband adoption and report current gaps to JCHC.	Adopted as a JCHC recommendation	SB842 Enacted
3. 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	Not included in final budget
4. Direct the Virginia Department of Health's Office of Emergency Medical Services to report to JCHC the draft regulations related to community paramedicine and mobile integrated healthcare.	Adopted as a JCHC recommendation	Not introduced
5. Establish or expand a grant program administered by the Virginia Department of Health's Office of Emergency Medical Services to provide funding to emergency medical services agencies for community paramedicine and mobile integrated healthcare programs.	Adopted as a JCHC recommendation	Not included in final budget
6. Direct the Department of Medical Assistance Services to cover HCPCS Code A0998 treatment without transport when Medicaid patients call 911.	Adopted as a JCHC recommendation	Not introduced

Policy option	JCHC action	General Assembly action
7. Direct 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.	Adopted as a JCHC recommendation	Not introduced
8. Direct the Department of Medical Assistance Services to seek approval and 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	Not introduced
9. Introduce a budget amendment to provide funding to Families Forward Virginia 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.	Adopted as a JCHC recommendation	Not included in final budget
10. Direct the Department of Medical Assistance Services, in conjunction with relevant stakeholders, to convene a workgroup to develop a plan for home visiting benefit for pregnant and postpartum individuals and their families.	Adopted as a JCHC recommendation	Not included in final budget
11. Introduce a budget amendment to provide an additional $2.5 million to the Virginia Department of Health (VDH) in FY 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. Report use of funds for prior years.	Adopted as a JCHC recommendation	Not introduced

Policy option	JCHC action	General Assembly action
12. Direct the Virginia Department of Health to report annually, the numbers of community health workers 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.	Adopted as a JCHC recommendation	SB981 Enacted
13. Direct 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).	Adopted as a JCHC recommendation	SB980 Failed to pass
14. Direct 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.	Incorporated into option 13 and adopted	N/A
15. Direct the Virginia Department of Health (VDH) to convene a work group to determine 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.	Incorporated into option 13 and adopted	N/A
16. Introduce a budget amendment to provide funding to the Virginia Community Health Worker Association (VACHWA) to, in partnership with relevant stakeholders, expand workforce development efforts for community health workers.	Adopted as a JCHC recommendation	Not introduced

Policy option	JCHC action	General Assembly action
17. Introduce a budget amendment to provide funding for a Telehealth Coordinator position at the Virginia Department of Health.	Adopted as a JCHC recommendation	Not introduced
18. Direct the Department of Behavioral Health and Developmental Services 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	SB1038 Enacted
19. Introduce a budget amendment to provide funding to allow the Virginia Telehealth Network 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.	Adopted as a JCHC recommendation	Not introduced
20. Direct 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	HB1945 & SB1037 Enacted
21. Direct DMAS 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.	Adopted as a JCHC recommendation	Not introduced
22. Direct 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.	Adopted as a JCHC recommendation	SB843 Enacted

Policy option	JCHC action	General Assembly action
23. Remove the exclusion of audio-only telephonic communication from the definition of telemedicine provided it's 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	Not introduced
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	Not included in final budget
25. Introduce a budget amendment to provide funding to Virginia Health Catalyst to plan and implement a pilot program, through Federal Qualified Health Centers and local community health centers, in which dental hygienists deliver teledentistry services in nursing homes.	Adopted as a JCHC recommendation	Not introduced
26. Require the Department of Corrections 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 and provide an update to the JCHC regarding the current status of telehealth policies.	Adopted as a JCHC recommendation	SB1039 Enacted

NOTE: General Assembly actions occurred during the 2025 legislative session.

TABLE 3: Legislative action on policy options for expanding access to sickle cell disease treatment in Virginia

Policy option	JCHC action	General Assembly action
1. Write a letter to request that the Virginia Department of Health provide an update on the plan for and status of the statewide sickle cell disease registry.	Adopted as a JCHC recommendation	N/A
2. Introduce a budget amendment to provide funds to the Virginia Department of Health (VDH) 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 and to develop a plan for and an estimate of the cost of addressing such need.	Adopted as a JCHC recommendation	Not introduced
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 need for transportation services for patient receiving services at comprehensive sickle cell treatment centers and to develop a plan for and an estimate of the cost of addressing such need.	Incorporated into option 2 and adopted	N/A
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.	Adopted as a JCHC recommendation	Not introduced

5. Direct 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	HB1675 Vetoed by Governor
6. Introduce a Section 1 bill directing the Department of Medical Assistance Services (DMAS) to include information on the status of the Commonwealth's participation in the Cell and Gene Therapy Access Model in the annual report.	Adopted as a JCHC recommendation	Not introduced
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.	Adopted as a JCHC recommendation	Not introduced
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.	Adopted as a JCHC recommendation	HB2757 Failed to pass

NOTE: General Assembly actions occurred during the 2025 legislative session.

TABLE 4: Legislative action on policy options for strategies to strengthen the anesthesia workforce in Virginia

Policy option	JCHC action	General Assembly action
1. Introduce a Section 1 bill directing the Board of Nursing to update regulations governing practice of advance practice registered nurses licensed as certified registered nurse anesthetists (CRNAs) to remove references to any specific edition of the American Association of Nurse Anesthetists' Standards for Nurse Anesthesia Practice.	No action taken	N/A
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	N/A
3. Introduce a Section 1 bill to require that the Department of Health Professions identify appropriate settings in which CRNAs may practice without supervision in the plan for transitioning CRNAs independent practice.	Failed to pass JCHC vote to adopt	N/A
4. Require the Department of Health Professions to license certified anesthesiologist assistants.	Adopted as a JCHC recommendation	HB1647 Failed to pass SB882 Enacted
5. Submit a budget amendment, providing funding to the Virginia Health Workforce Development Authority (VHWDA) to study the capacity and needs of current anesthesiology residency programs and CRNA training programs in Virginia and make recommendations for further expansion.	Adopted as a JCHC recommendation	Not included in final budget

NOTE: General Assembly actions occurred during the 2025 legislative session.

Appendix B: Study resolutions

Study Resolution

Policy Solutions to the Commonwealth's Fentanyl Crisis

Authorized by the Joint Commission on Healthcare on December 17, 2024

2024 SESSION

ENROLLED

HOUSE JOINT RESOLUTION NO. 41

Directing the Joint Commission on Health Care to study policy solutions to the Commonwealth's fentanyl crisis. Report.

Agreed to by the House of Delegates, February 12, 2024
Agreed to by the Senate, March 5, 2024

WHEREAS, in 2022 there were 2,490 drug overdose deaths among Virginians; and

WHEREAS, nearly eight out of 10 drug overdose deaths in Virginia in 2022 were caused by fentanyl, fentanyl analogs, and tramadol; and

WHEREAS, there were 22,398 drug overdose emergency department visits among Virginians in 2022, a five percent increase from 2021; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study policy solutions to the Commonwealth's fentanyl crisis.

In conducting its study, the Joint Commission on Health Care shall (i) study the causes of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth, (ii) study the impact of the rise in fentanyl prevalence and fentanyl overdoses in the Commonwealth on Virginians and the Commonwealth's health care system, (iii) study and provide insight into the fentanyl crisis within the context of other drug crises and addiction trends in recent history, and (iv) establish and make policy recommendations related to reducing the prevalence of fentanyl in the Commonwealth and reducing the number of fentanyl overdoses in the Commonwealth.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings by November 30, 2025, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

ENROLLED

HJ41ER

Study Resolution

Strategies to Address Pharmacy Deserts

Authorized by the Joint Commission on Healthcare on December 17, 2024

WHEREAS, pharmacy services include dispensing of medication, patient education, vaccinations, and testing services; and

WHEREAS, pharmacies can be an important community asset, providing access to essential health services for members of the surrounding community, particularly in areas with limited access to primary care providers; and

WHEREAS, pharmacy deserts, geographical areas characterized by limited access to pharmacy services, are associated with lower medication adherence and poor health outcomes for members of the surrounding community, and research suggests medically underserved populations are more likely to live in pharmacy deserts; and

WHEREAS, nationally, one in eight pharmacies, a majority of which were independent pharmacies, ceased operation between 2009 and 2015 and, more recently, large retail pharmacy chains announced over 2,000 additional pharmacy closures nationally, including many locations in Virginia over the next three years; and

WHEREAS, many factors contribute to pharmacy closures and loss of access to pharmacy services in Virginia, including reduced sales, low reimbursement rates, and low dispensing fees under Medicaid; and

WHEREAS, implementing strategies to ensure access to pharmacy services could improve the health and well-being of Virginians; now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study access to pharmacy services in Virginia.

The study shall (i) describe how access to pharmacy services has changed in Virginia over time, and the impact of changes in access to pharmacy services on Virginians, (ii) identify areas in Virginia that constitute pharmacy deserts, and describe populations in Virginia that are impacted by pharmacy deserts, (iii) identify factors that impact access to pharmacy services in Virginia, including state and federal law, (iv) describe strategies to ensure access to pharmacy services, including strategies implemented in other states, and (v) recommend policy options through which the state may ensure access to pharmacy services.

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 Department of Medical Assistance Services, the Department of Social Services, the Department of Behavioral Health and Developmental Services, the Department of Health Professions, and the Department of Health shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Study Resolution

Transportation-Related Barriers to Health Care

Authorized by the Joint Commission on Healthcare on December 17, 2024

WHEREAS, limited transportation options can impact a patient's ability to access health care services; and

WHEREAS, it is estimated that more than one in five adults with limited public transit access forgo health care because of transportation barriers; and

WHEREAS, individuals who are older, of lower socioeconomic status, living in rural communities, or who have chronic health conditions or disabilities may be particularly impacted by transportation barriers to health care; and

WHEREAS, individuals who experience transportation barriers to healthcare may skip or delay care or miss appointments, leading to poorer health outcomes and higher health care costs; and

WHEREAS, multiple organizations, such as the House Select Committee on Rural Health, the Virginia Department of Health, and the Joint Legislative Audit and Review Commission, have identified transportation barriers to healthcare as a pressing issue in many localities in the Commonwealth; and

WHEREAS, implementing strategies to reduce transportation barriers to healthcare could improve the health and well-being of Virginians; now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study transportation-related barriers to health care.

In conducting its study, staff shall (i) describe the types of transportation barriers to health care that exist in Virginia, the factors that contribute to the existence of such barriers, and the populations that are most affected by such barriers; (ii) identify and evaluate existing interventions and programs that address transportation barriers to health care in Virginia; (iii) identify strategies Virginia could implement to address transportation barriers, including strategies that have been implemented by other states; and (iv) recommend policy options through which the state may reduce transportation barriers to health care for patients in Virginia.

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, information, and data to the Joint Commission on Health Care for this study upon request.

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