JOINT COMMISSION ON HEALTH CARE

2025 INTERIM EXECUTIVE SUMMARY

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT # 170

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

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 27, 2026

The Honorable Abigail Spanberger
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 Spanberger 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 2025 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 2025

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 2025 to implement this purpose.

Staff Reports and Legislative Recommendations

During 2025, JCHC staff completed five studies (two targeted) as directed by the Commission. At the conclusion of each study, members received a written report. Members received a briefing on and had the opportunity to vote on policy options for four of the five studies completed in 2025. The following are summaries of the reports.

Policy Solutions to the Commonwealth's Fentanyl Crisis

Virginia has implemented multiple evidence-based strategies to prevent fentanyl overdose deaths and increase access to opioid use disorder treatment. Death rates from fentanyl overdoses have also decreased, with a 45 percent decline between 2023 and 2024. However, fentanyl overdose death rates still far exceed death rates from most other types of illicit drugs and death rates from 2016, when the opioid epidemic was first declared a public health emergency.

Illicit fentanyl is highly addictive, readily available, and deadly

Pharmaceutical fentanyl produces a more intense high, relative to other opioids, creating an increased potential for misuse and dependence. As prescription opioids became harder to obtain, illicit manufactured fentanyl increased in availability. Illicit fentanyl is manufactured in clandestine labs and distributed through illegal drug markets. It is a profitable narcotic as it is highly potent, cheaply made, and easily transported. Inconsistent manufacturing methods, however, result in various levels of fentanyl potency that are difficult to discern and therefore increase the risk of overdose death.

The impact of illicit fentanyl has changed over time in Virginia

Illicit fentanyl represents the third wave of opioid overdose deaths in Virginia, beginning in 2013 and rapidly increasing until 2021. In recent years, rates stabilized and then fell precipitously between 2023 and 2024. Multiple factors contribute to the change in illicit fentanyl deaths, including lack of education on the risks of fentanyl, limited availability of appropriate harm reduction strategies, and the COVID-19 pandemic. Data indicates that males, Black or African American individuals, and individuals between the ages of 35 and 44 experienced the highest rates of overdose deaths from fentanyl.

Virginia is successfully implementing evidence-based strategies to address illicit fentanyl use

Staff identified 53 state-funded or state-administered strategies across 18 agencies that address surveillance, prevention, intervention, treatment, and recovery efforts. Stakeholders expressed concerns about the continuity of focus on preventing overdoses, the likelihood of sustained state funding, and the lack of information on the effectiveness of efforts that were rapidly implemented. Designating a lead agency in the Commonwealth for comprehensive opioid response may assist with sustainability.

Virginia can take additional steps to enhance ongoing efforts

Virginia programs, legislation, and funding have increased the availability of opioid antagonists. The Virginia Department of Health (VDH) requires continued state funding to distribute naloxone for free or at cost to eligible organizations. Costs to patients for opioid antagonists are also a barrier. The state has made efforts to increase access to medications for opioid use disorder, but counseling co-requirements may prevent providers from initiating treatment. The expansion of peer recovery services is limited by hiring practices that prevent hiring of peers for some positions that may benefit from the candidate's lived experience.

Gaps exist in efforts to address illicit fentanyl use for certain high-needs populations

Pregnant and parenting women who use fentanyl face unique barriers and need specialized supports. Funding to establish Project LINK sites could expand access to services for this population. The need for substance use services is significantly higher in incarcerated populations than in the general population. Recruiting and retaining health care staff to serve the incarcerated population is difficult, but workforce incentive programs may help. In addition, state investments in treatment and transition services for incarcerated individuals need additional flexibility to encourage expansion.

Members voted unanimously to adopt the following policy options:

- **Option 1** – Designate VDH as the lead agency for comprehensive opioid response in the Commonwealth.
- **Option 2** – Appropriate funds to optimally fund VDH's opioid antagonist distribution program.
- **Option 3** – Direct VDH to develop a methodology for estimating future costs of the opioid antagonist distribution program.
- **Option 4** – Remove requirement for VDH to purchase eight milligram naloxone nasal spray.
- **Option 5** – Require health insurers to cover at least one prescription and at least one over-the-counter opioid antagonists at no cost to patients. (Amended)
- **Option 6** – Amend regulations to clarify initiation of medications for opioid use disorder when psychosocial counseling is refused or unavailable.
- **Option 7** – Direct VDH and Virginia Department of Corrections to develop guidelines for hiring peer recovery specialists with lived experience.
- **Option 8** –Appropriate funding to establish three additional Project LINK programs at CSBs to treat pregnant women who use substances. (Amended)
- **Option 9** – Direct VDH to develop and implement a plan to expand workforce incentive programs to medical staff in local and regional jails.
- **Option 10** – Sunset the model addiction recovery program; move funds from the model addiction recovery program to the Jail Mental Health Pilot Program (the Program); increase funding to expand the Program to additional sites and direct the Department of Criminal Justice Services, in consultation with the Department of Behavioral Health and Developmental Services, to develop criteria for the selection of additional grantees for the Program and time limits for the duration of grants awarded to ensure additional grantees have the opportunity to compete for funds provided by the Program in the future. (Amended)
- **Option 11** –Appropriate funds to expand the Virginia Opioid Use Reduction and Jail-Based Substance Use Disorder Treatment and Transition Program to additional sites.

Strategies to Address Transportation-Related Barriers to Health Care

Reliable transportation is an essential part of accessing health care services. Inadequate transportation can result in health burdens such as increased emergency department visits, poor chronic condition management, and poor health outcomes. In 2020, the Virginia Department of Rail and Public Transit (DRPT) reported that approximately six percent of households statewide did not have a vehicle available to them. In the Southwest region, seven percent of households lacked access to a vehicle, and in some pockets of Virginia, more than half of households lived without a car. Lack of available public transportation, inability to navigate complex transportation services, and programmatic barriers may also prevent individuals from accessing transportation to health care services. Both federal- and state-level programs exist to increase access to transportation services, particularly for high-needs populations. However, these programs are challenged to provide services to all eligible populations.

The Virginia NEMT Program has improved in recent years, but data collection could be enhanced

The non-emergency medical transport (NEMT) program has improved on-time performance and unfilled trips. Department of Medical Assistance Services (DMAS) collects performance data for the fee-for service NEMT program on several metrics; however, they do not specify performance metrics for managed care organizations (MCOs) to include in contracts with transportation brokers. As a result, Virginia's Medicaid MCOs are tracking and collecting performance metric data differently.

Fixed funding hinders expansion of transportation services for Section 5310 program recipients

Rising capital costs and costs of program operations without an increase in funding makes it impossible to expand services. The fixed allocation formula for Section 5310 Program funds limits the funding available for transportation programs in small urban and rural areas of the Commonwealth.

Transportation services in Virginia are siloed, limiting access and making coordination across programs difficult

The complexity of the siloed transportation system makes it difficult for patients to find appropriate services and creates barriers for patients who have to navigate different eligibility requirements, service areas, and other service guidelines to access transportation services. Increased coordination of transportation services can help address this issue.

Rural areas of Virginia need additional transportation options and resources

National estimates indicate that rural residents live an average of 10.5 miles from the nearest hospital, compared to 4.4 miles in urban areas. When public transportation is available in rural areas, it may not serve the entire population. Microtransit could be a solution to increase transportation to health care in rural areas.

Members voted unanimously to adopt the following policy options:

- **Option 1** –Direct DMAS to amend contracts with Medicaid MCOs to require the MCOs to adopt performance metrics for NEMT brokers consistent with performance metrics implemented for the fee-for-service program.
- **Option 2** –Direct DMAS to develop guidance for Medicaid MCOs regarding mileage requirements for nonemergency medical transportation prior authorizations.

Members voted to adopt the following recommendations by a 7 Yes – 1 No – 2 Abstain vote:

- **Option 3** –Introduce a budget amendment to increase the portion of the Commonwealth Mass Transit Fund (the Fund) dedicated to supporting human services transportation programs that provide paratransit services and enhanced transportation services for older adults and persons with disabilities to 0.0045% of the total amount included in the Fund.
- **Option 4** –Introduce a budget amendment to add $500,000 per year to the Commonwealth Mass Transit Fund for DRPT to provide technical assistance on program financial management to Section 5310 Program grantees.
- **Option 5** – Introduce a budget amendment to provide up to $8 million per year for the DRPT to establish a competitive grant program for private, non-profit organizations and state or local government agencies to plan, establish, and sustain mobility management services or regional transportation hubs that include mobility management services.
- **Option 6** –Introduce a budget amendment to provide up to $5 million per year to the DRPT to establish a competitive grant program to provide funding to localities to plan, establish, and sustain microtransit services in rural areas of Virginia.

Access to Pharmacy Services in Virginia

Community pharmacies serve all members of the public, dispensing medications and providing critical health services such as testing and initiating treatment for certain

illnesses and administering vaccinations. Community pharmacies are more accessible than other pharmacy services options for more individuals, providing significant benefit to the community. Community pharmacies are staffed with highly trained health care professionals, typically open longer hours than other health care providers, and provide opportunities for in-person counseling about medications and other health-related education. Beginning in 2019, the total number of community pharmacies operating in Virginia has declined each year, with a total decline of nearly 10 percent between 2019 and 2024.

Community pharmacies are a critical access point for health care services

Community pharmacies, including independent, chain, and government-funded or philanthropic pharmacies, dispense medications and provide clinical services that improve medication adherence and health outcomes for patients. Limited access to community pharmacies negatively impacts health outcomes.

Access to community pharmacies is changing in Virginia

The total number of community pharmacies operating in Virginia has declined steadily since 2019, leaving a growing number of localities in the Commonwealth with limited access to pharmacy services. Twenty-two localities have only one or no community pharmacy within its borders.

Imbalance between pharmacy expenses and revenue is the primary driver of pharmacy closures

Reimbursement rates for dispensing of medications are not sufficient to offset the expense of purchasing, stocking, and dispensing drug products. This loss results in financial pressures that drive pharmacy closures.

States can reduce financial challenges for pharmacies by addressing practices that limit pharmacy revenue

Virginia has implemented some limits on PBM practices that impact pharmacy revenue. Establishing minimum reimbursement fees for pharmacies when the state is the payer, including through the Commonwealth's Medicaid program, could further address financial challenges affecting community pharmacies.

States can provide incentives to maintain or re-establish pharmacies in low access communities

Pharmacies in rural communities face unique challenges to sustaining operations, including smaller populations, lower sales volumes, and high rates of Medicaid enrollment. Incentive programs provide direct financial support to select pharmacies or pharmacists meeting certain criteria in limited access areas. Additional funding for government-funded pharmacy services could expand access in areas with no pharmacies.

Members voted to adopt the following recommendations by a 10 Yes – 1 Abstain vote:

- **Option 1 -** Direct DMAS to (i) release the report of the 2024 Cost of Dispensing survey to the General Assembly no later than August 1, 2026, and (ii) propose a minimum dispensing fee for medications dispensed to Medicaid members, including those enrolled in Fee-for-Service and managed care arrangements, that includes reimbursement for drug ingredient costs and a professional dispensing fee. The legislation or budget amendment should direct DMAS to report the proposed reimbursement rate or rates, the methodology for determining the amount or amounts proposed, and the potential fiscal impact of the proposed amount or amounts to the General Assembly. (Amended)
- **Option 2 -** Introduce legislation and submit a budget amendment to establish an incentive program to provide funding pharmacies operating in localities with low access to community pharmacies.
- **Option 3-** Submit a budget amendment to increase funding to the Virginia Association of Free and Charitable Clinics and the Virginia Community Healthcare Association to expand access to pharmacy services provided by existing clinics and community health centers to localities with no operating community pharmacies.
- **Option 4 (added) -** Establish (i) a methodology for determining the amount of the drug ingredient cost and (ii) a minimum professional dispensing fee to be paid by a pharmacy benefit manager to a pharmacist or pharmacy for dispensing of a medication.

Strategies for Legislative Oversight of Medicaid Program Spending (Targeted study)

Virginia's Medicaid program provides health care to low-income individuals and, in terms of state dollars invested, is one of the largest programs in Virginia. As stewards of taxpayer dollars, the General Assembly strives to ensure that the Medicaid program operates efficiently and effectively. In response to significant additional investment in Medicaid over the past decade, the Virginia General Assembly has attempted to improve legislative oversight of program spending through additional agency reporting requirements, the creation of external committees and councils, and increased involvement in the Medicaid forecasting process. Legislative oversight of Medicaid in Virginia has increased; however, current efforts may need to be enhanced to meet the needs of the Virginia General Assembly and provide more comprehensive oversight of Medicaid program spending in Virginia.

State oversight of the Medicaid program is necessary to ensure proper program implementation and appropriate use of funds

States may implement oversight activities to ensure state funds are used effectively and efficiently to accomplish the purpose and goals of the Medicaid program. In Virginia, the Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program consistent with guidelines established and within the limits of funding appropriated by the General Assembly. Given the current growth in the cost and complexity of the program, additional efforts may be needed to improve the ongoing monitoring and analysis of the Medicaid program.

The General Assembly has implemented several strategies to enhance oversight of Medicaid program spending

Current oversight efforts include: (1) directing DMAS to report data and information about the Medicaid program to the General Assembly, (2) expanding the role of the General Assembly and legislative staff in the Medicaid forecasting process, (3) establishing the Joint Subcommittee for Health and Human Resources Oversight, and (4) directing the Joint Legislative Audit and Review Commission to study and provide analyses of Health and Human Resources agencies.

Current efforts provide information and data on the Medicaid program but do not incorporate all aspects of program oversight

Overall, current oversight efforts provide legislators with information and data on the Medicaid program but do not incorporate all aspects of program oversight. Oversight efforts are dispersed among numerous entities and are not structured or staffed to provide continuous, proactive, and preventative monitoring and analysis of the data and information received.

Members voted to adopt the following recommendation unanimously:

- **Option 3:** The JCHC could submit a budget amendment to direct the Joint Subcommittee on Health and Human Resources Oversight (the Joint Subcommittee) to provide continuous oversight of the Commonwealth's Medicaid program and to clarify the roles and responsibilities of agencies charged with providing support for and facilitating the work of the Joint Subcommittee.

Implementation of a Medicaid ILOS Food and Nutrition Benefit for Pregnant and Postpartum Women and Individuals Living with Diabetes (Targeted study)

The prevalence of diet-related chronic conditions like obesity, cardiovascular disease, hypertension, and diabetes is increasing in Virginia. Interventions that provide nutritional counseling and access to healthy foods can improve health outcomes, reduce health-related complications, and lower health care costs for individuals with diet-related chronic conditions. Virginia's Medicaid program presents an opportunity to provide nutritional interventions for individuals with diet-related chronic conditions who may be experiencing barriers to accessing healthy foods.

Increase in diet-related chronic conditions is due, in part, to poor nutrition

Diet-related chronic conditions (DRCCs) such as obesity, cardiovascular disease, hypertension, and diabetes are increasing in prevalence and require significant health care resources. Diet quality is a modifiable risk factor for these chronic conditions. Barriers to accessing nutritious foods and lack of information contribute to increasing rates of DRCCs in Virginia.

Nutrition interventions can reduce barriers to a healthy diet and improve health outcomes

Nutrition interventions can address factors that contribute to development and progression of DRCCs. Food is Medicine (FIM) nutritional interventions such as medically tailored meals, medically tailored groceries, and produce prescriptions are implemented in clinical settings to treat or manage DRCCs.

States can implement food and nutrition interventions through their Medicaid programs

Federal rules offer several policy pathways for states to offer optional benefits, including nutrition benefits: state plan amendments (SPAs), Section 1915(c) home- and community-based services waivers, Section 1115 demonstration waivers, and managed care in-lieu-of-services and settings (ILOS) benefits. Similar to several other states, Virginia could authorize an ILOS benefit to make food and nutrition services available to Medicaid members.

The written report included one policy option:

- **Option 1:** Direct the Department of Medical Assistance Services to develop a plan for a nutrition ILOS managed care benefit, including (i) descriptions of the services proposed to be covered and the covered services for which they will substitute and categories of individuals who will be eligible for the service, (ii) evidence of cost-effectiveness of the services proposed to be covered and the cost percentage of the services proposed to be covered, (iii) provisions for

monitoring and oversight of the ILOS to meet federal requirements, and (iv) any other information required to be provided to the Centers for Medicare and Medicaid Services to support authorization of the ILOS, and report on the plan, together with information about required next steps for implementation of the ILOS and any implementation considerations, to the General Assembly and the JCHC by October 1, 2026.

The final report was provided to JCHC members and included on the JCHC's website but was not presented. Members did not vote on the policy option contained in the report.

Stakeholder briefings

During the July 23rd meeting, Dr. Karen Shelton, State Health Commissioner for the Virginia Department of Health, presented information on several topics. She provided information about the regulation of nursing homes and hospitals in Virginia. She described certification requirements for nursing homes, current trends in complaints, investigations undertaken in response to complaints, and efforts to address issues related to case backlogs and delays in performing required investigations. Dr. Shelton discussed staffing at OLC and listed goals and initiatives to help recruit new staff. She described certification requirements for and current trends in complaints about Virginia hospitals. She spoke about deficiencies related to the operation of the Henrico Doctor's Hospital Neonatal Intensive Care Unit and actions VDH is taking to ensure the deficiencies are corrected, including ongoing monitor of the hospital. Lastly, Dr. Shelton briefed members on the Ryan White HIV/AIDS Program. She discussed the details of grants that cover the medical and support services for the program and described recent cuts to program funding

Ms. Cheryl Roberts, Director of the Virginia Department of Medical Assistance Services, provided an update on the Cardinal Care Managed Care, then briefed members on provisions of the One Big Beautiful Bill Act. She described changes to the enrollment and eligibility determination process and retroactive coverage provisions; changes to rules governing provider taxes and state directed payments; new community engagement and work requirements; changes to cost sharing requirements; adjustment to home or community-based services; and the new Rural Health Transformation Program.

Mr. Kyle Russel, Chief Executive Officer for Virginia Health Innovation, provided a briefing on VHI's annual report. He described the origins and purpose of VHI and how it evolved over the years. He also described the type of data and information the organization collects, and how that data and information is used and distributed. He

spoke about the projects that VHI accomplished this year and discussed the priorities that are planned for next year.

Ms. Beth Bortz, President & CEO of the Virginia Center for Health Innovation (VCHI) provided a brief overview of the organization and gave an update on the primary care task force accomplishments including their four pilots. She discussed the three recommendations from the pilots that will require legislative action and reasons for the requirements. Next, VCHI's Chief Strategy Officer Dr. Lauryn Walker discussed the details of the primary care investment report including spending, workforce, and patient outcomes. She also spoke about recent work and planned future activities of VCHI's Research Consortium.

During the November 6th meeting, Commissioner Nelson Smith, Department of Behavioral Health and Developmental Services, briefed members on the final plan for the Hiram Davis Medical Center closure. The Commissioner presented data on the current census of patients and the ways in which the current staff have been supported throughout the planning process. He spoke about the different options for expanding or renovating Central State Hospital to accommodate HDMC patients that were offered by stakeholders and through public comments. Commissioner Smith described the new locations within communities to which current patients will be moved after the closure, including newly renovated accommodations at Southeastern Virginia Training Center. He also spoke about the staff at HDMC and their preferences for transfers to other facilities. Next, Commissioner Smith described the projected six-year costs for either closing or renovating the medical center. Lastly, the Commissioner provided a timeline for implementation of the plan.

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 21st
- June 18th
- July 23rd
- September 17th
- October 22nd
- November 6th - virtual
- December 3rd

Executive Subcommittee

- May 21st
- October 22nd

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 at the Virginia Health Department (VDH) conference, and participated as a guest lecturer on public policy matters for graduate courses at the University of Virginia and Virginia Commonwealth University. Additionally, staff attended the American Society of Health Economists conference, National Conference of State Legislatures Annual Meeting, the Congressional Black Caucus Foundation conference, and the American Public Health Association conference.

JOINT COMMISSION ON HEALTH CARE

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