

JOINT COMMISSION ON HEALTH CARE

2025 ANNUAL REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT #539

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

Members (2025)

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

Delegate N. Baxter Ennis*

Senator Barbara A. Favola

Delegate C.E. (Cliff) Hayes, Jr.

Senator Christopher T. Head

Delegate M. Keith Hodges

Delegate Patrick A. Hope

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Senator Todd E. Pillion

Delegate Marcia S. Price

Delegate Atoosa R. Reaser

Delegate Mark D. Sickles*

Senator David R. Suetterlein

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JOINT COMMISSION ON HEALTH CARE

Senator Barbara A. Favola, Chair Delegate Patrick A. Hope, Vice Chair

September 1, 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
201 N Ninth Street
Richmond, Virginia 23219

Dear Governor Spanberger 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 2025 and legislative action taken by the Commission during the 2026 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,

Barbara A. Favola, Chair

Joint Commission on Health Care 2025 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).

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 (now Lieutenant Governor) Ghazala Hashmi served as the Vice Chair in 2025.

2025 Staff Reports

In 2025, JCHC staff completed reports and briefings on five topics:

- [Policy Solutions to the Commonwealth’s Fentanyl Crisis](#)
- [Strategies to Address Transportation-Related Barriers to Health Care](#)
- [Access to Pharmacy Services in Virginia](#)
- [Strategies for Legislative Oversight of Medicaid Program Spending](#)
- [Implementation of a Medicaid In Lieu of Service Food and Nutrition Benefit for Individuals with Diet-Related Chronic Conditions](#)

Policy Solutions to the Commonwealth’s Fentanyl Crisis

Report Summary

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.

Legislative Impact

This study included 11 policy options, all of which were adopted by the JCHC as policy recommendations.

Fourteen bills (7 pairs of companion bills) implementing policy recommendations resulting from this study were introduced during the 2026 Session of the General Assembly and all 14 were enacted by the General Assembly.

Four budget amendments implementing policy recommendations resulting from this study were introduced during the 2026 Session of the General Assembly, and three were included in whole or in part in the final Appropriation Act of 2026, Special Session I.

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

Strategies to Address Transportation-Related Barriers to Health Care

Report Summary

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.

Legislative Impact

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

Three budget amendments implementing policy recommendations resulting from this study were introduced during the 2026 Session of the General Assembly, and one was included in the final Appropriation Act of 2026, Special Session I.

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

Access to Pharmacy Services in Virginia

Report Summary

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.

Legislative Impact

This study included three policy options and a fourth was added by members after hearing the briefing. All four policy options were adopted by the JCHC as policy recommendations.

Two budget amendments implementing policy recommendations resulting from this study were introduced during the 2026 Session of the General Assembly; however, none were included in the final Appropriation Act of 2026, Special Session I.

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

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

Summary

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.

Legislative Impact

This study included four policy options. One policy option was adopted as a policy recommendation but the budget amendment was not introduced in the 2026 session.

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

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

Summary

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.

Legislative Impact

The final report was provided to members but not presented. The one policy option contained in the report was not introduced in the 2026 session.

(See Appendix A, Table 5 for policy option and legislative outcome for this study.)

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.

Commission Meetings

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

Full Commission

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

Executive Subcommittee

- May 21st
- October 22nd

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

2026 Staff Studies

During the October 2025 meeting, JCHC members requested informational briefings on four topics to be provided in the spring of 2026:

- Federal Medicaid program changes (this project was continued to the fall of 2026);
- The financial condition of Virginia's rural hospitals;
- Public health impacts of e-cigarette use and e-cigarette retailers; and
- Role of assisted living facilities (ALF) in the continuum of long-term care services.

At the December 2025 meeting, the ALF topic was removed from the workplan to avoid duplicating work expected to be completed by the Joint Legislative Audit and Review Commission.

At the May 2026 meeting, JCHC members added three projects to the staff work plan:

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- A continuation of the information brief on the impact of HR 1's changes to the federal Medicaid program and the impact of those changes on Virginia's hospitals
- An evaluation of Virginia's nursing facility workforce and considerations for staffing standards pursuant to HB 605 (Willett), and
- A targeted study of the liquid nicotine and nicotine vapor products directory pursuant to SB 789 (Reeves).

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 policy solutions to the Commonwealth's fentanyl crisis.

Policy option	JCHC action	General Assembly action
1. Submit legislation to amend the Code of Virginia to designate VDH as the lead agency for comprehensive opioid response in the Commonwealth and to direct relevant state agencies to work with VDH to create, implement, and monitor a statewide strategic plan for opioid response.	Adopted as a JCHC recommendation	Enacted, Acts of Assembly Chapter 667 & Chapter 668 Item 278. N. of the Appropriation Act of 2026, Special Session I
2. Introduce a budget amendment appropriating funding each fiscal year to VDH from the Commonwealth's Opioid Abatement and Remediation Fund or state general funds to maintain the Commonwealth's opioid antagonist distribution program	Adopted as a JCHC recommendation	Not introduced
3. Introduce a budget amendment directing VDH to develop a methodology to estimate annual naloxone distribution program costs based on available data and to report annually on such estimates to the JCHC and the Chairs of HAC and SFAC by December 1 each year.	Adopted as a JCHC recommendation	Enacted, Acts of Assembly Chapter 729 & Chapter 1024
4. Submit a language-only budget amendment removing the requirement that VDH dedicate \$1 million of its naloxone distribution program budget to the purchase and distribution of 8mg naloxone nasal spray.	Adopted as a JCHC recommendation	Introduced but not included in the Appropriation Act of 2026, Special Session I
5. Amend the Code of Virginia to require health insurers to include at least one opioid antagonist nasal spray on its formulary; prohibit prior authorization or any other	Adopted as a JCHC recommendation	Enacted, Acts of Assembly Chapter 423 & Chapter 424

Policy option	JCHC action	General Assembly action
requirements other than those imposed by state and federal law for these drugs; provide coverage for any FDA-approved over-the-counter opioid antagonist; not impose any copayment or other out-of-pocket expense for these drugs.		
6. Submit legislation directing the Boards of Dentistry and Medicine to amend regulations that require providers to offer counseling or referral to counseling to clarify that patients' participation in counseling is not required for office-based buprenorphine treatment.	Adopted as a JCHC recommendation	Enacted - Acts of Assembly Chapter 207 & Chapter 208
7. Submit Section 1 bills directing VDH and VADOC to develop agency guidelines for hiring peer recovery specialists with previous criminal convictions for compensated employment.	Adopted as a JCHC recommendation	Enacted – Acts of Assembly Chapter 90 & Chapter 91
8. Submit a budget amendment for \$1.5 million to DBHDS to establish additional Project LINK programs at CSBs in areas with limited treatment options for pregnant women, based on criteria established by DBHDS.	Adopted as a JCHC recommendation	Not introduced
9. Submit a Section 1 bill or language-only budget amendment directing VDH to work with relevant stakeholders to develop and implement a plan to expand workforce incentive programs to health care workers in local and regional jails.	Adopted as a JCHC recommendation	Not introduced
10. Submit a budget amendment to expand funding for the Jail Mental Health Pilot Program; permit DCJS, in consultation with DBHDS, to develop criteria to select additional grantees; establish time limits for the duration of grants awarded to ensure additional grantees have the opportunity to compete for funds in the future.	Adopted as a JCHC recommendation	Item 394.X. of the Appropriation Act of 2026, Special Session I

Policy option	JCHC action	General Assembly action
11. Submit legislation and a budget amendment to sunset the model addiction recovery program; move funds from the model addiction recovery program to the JSUT Fund; appropriate funds for an additional cohort of three-year JSUT program grantees; direct DCJS to provide technical assistance to current grantees of the model addiction recovery program.	Adopted as a JCHC recommendation	Item 394.J. of the Appropriation Act of 2026, Special Session I

NOTE: General Assembly actions occurred during the 2026 legislative session.

TABLE 2: Legislative action on policy options for strategies to address transportation-related barriers to health care.

Policy option	JCHC action	General Assembly action
1. Direct the Department of Medical Assistance Services (DMAS) to amend contracts with Medicaid managed care organizations (MCOs) to require adoption of performance metrics for Medicaid Non-Emergency Medical Transportation (NEMT) brokers consistent with performance metrics implemented for the Fee-for-Service NEMT program and to report annually to DMAS regarding the performance of the NEMT brokers on such metrics.	Adopted as a JCHC recommendation	Item 291.VVVVV. of the Appropriation Act of 2026, Special Session I
2. Direct DMAS to develop guidance to MCOs regarding NEMT mileage prior authorization requirements. DMAS should develop a recommended mileage amount for which prior authorization is not allowable.	Adopted as a JCHC recommendation	Introduced but not included in the Appropriation Act of 2026, Special Session I
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.	Adopted as a JCHC recommendation	Not introduced
4. Introduce a budget amendment to add \$500,000 per year to the Commonwealth Mass Transit Fund for the Department of Rail and Public Transportation (DRPT) to provide technical assistance on program financial management to Section 5310	Adopted as a JCHC recommendation	Not introduced

Policy option	JCHC action	General Assembly action
Program grantees, including guidance on braiding of federal funds and how to establish themselves as Medicaid Non-Emergency Medical Transportation providers.		
5. Introduce a budget amendment to provide up to \$8 million per year for the Department of Rail and Public Transportation (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.	Adopted as a JCHC recommendation	Not introduced
6. Introduce a budget amendment to provide up to \$5 million per year to the Department of Rail and Public Transportation to establish a competitive grant program to provide funding to localities to plan, establish, and sustain microtransit services in rural areas of Virginia.	Adopted as a JCHC recommendation	Introduced but not included in the Appropriation Act of 2026, Special Session I

NOTE: General Assembly actions occurred during the 2026 legislative session.

TABLE 3: Legislative action on policy options for access to pharmacy services in Virginia.

Policy option	JCHC action	General Assembly action
1. Submit a budget amendment to set a reimbursement fee floor for drug ingredient costs and professional dispensing fees paid to community pharmacies for all medications dispensed to Medicaid members, including those enrolled in Fee-for-Service and managed care arrangements	Adopted as a JCHC recommendation	Introduced but not included in the Appropriation Act of 2026, Special Session I
2. Introduce legislation and submit a budget amendment to establish an incentive program to provide funding for pharmacies operating in localities with low access to community pharmacies.	Adopted as a JCHC recommendation	Not introduced
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.	Adopted as a JCHC recommendation	Introduced but not included in the Appropriation Act of 2026, Special Session I
4. The General Assembly should 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.	Adopted as a JCHC recommendation	Not introduced

NOTE: General Assembly actions occurred during the 2026 legislative session.

TABLE 4: Legislative action on policy options for Medicaid program oversight.

Policy option	JCHC action	General Assembly action
1. Submit legislation and a budget amendment to establish a new legislative commission with dedicated staff to provide oversight of the Medicaid program, including regular analysis of Medicaid program operations, outcomes, and expenditures, as well as policy analyses and other studies to provide recommendations about issues selected by commission members or referred by the General Assembly	Adopted as a JCHC recommendation	Not introduced
2. Submit legislation to direct JLARC or the JCHC to conduct oversight of the Medicaid program and a budget amendment to add four additional staff positions (two policy analysts and two fiscal analysts) to JLARC or JCHC to allow the commission to carry out required oversight activities.	No action taken	N/A
3. Submit a budget amendment to direct the Joint Subcommittee on Health and Human Resources Oversight to provide comprehensive, 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.	No action taken	N/A
4. Submit a budget amendment to add two staff positions to both the House Appropriations and Senate Finance and Appropriation Committees. Additional staff could be tasked with supporting the Joint Subcommittee on Health and Human Resources Oversight generally or with carrying out oversight of the Medicaid program specifically.	No action taken	N/A

NOTE: General Assembly actions occurred during the 2026 legislative session.

TABLE 5: Legislative action on policy options for Medicaid ILOS food and nutrition benefit.

Policy option	JCHC action	General Assembly action
5. Direct DMAS to develop a plan for a nutrition “in lieu of” service (ILOS) managed care benefit,	No action taken	N/A

NOTE: General Assembly actions occurred during the 2026 legislative session.



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