JCHC Commission Meeting

October 23, 2024

Meeting Agenda

Review of JCHC Voting Process and Rules

Performance of Health Care Workforce Programs

- Update on Public Comment Received
- Voting on Policy Options

Results of Study of Strategies to Extend Health Care Access to Vulnerable Populations

Update on 2025 Study Priorities

JCHC voting process

- Staff will provide a brief overview of the study findings and policy options and any public comment received
- Chair will open the floor for discussion, questions, and motions from JCHC members

JCHC voting rules

- Members may move to adopt policy options as JCHC recommendations
  - Members may amend or add policy options
- Adopting a recommendation requires a majority vote of the members present
  - Must include at least half of the members present from both the House and Senate

Staff assistance with JCHC recommendations

- Chair will solicit volunteers to patron legislation or budget amendments to implement recommendations
- Staff will work with patrons' offices to prepare draft language and provide support during the General Assembly session

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Update on 2025 Study Priorities

Performance of Health Care Workforce Programs

Lead Analyst: Jen Piver-Renna

Study purpose

- Develop a framework for measuring the performance and impact of health care workforce programs
- Obtain relevant data to populate metrics measuring each program's outputs and outcomes
- Develop and implement a process for reporting on the performance of programs that is meaningful, transparent, and actionable
- Consider policy options through which the state may improve the performance of health care workforce programs

Study resolution approved by Commission on December 6, 2023

Findings in brief

- During the last biennium, Virginia appropriated $683 million in state funds for 34 health care workforce programs
- Programs are reaching their intended audience but lack focus on areas of most need
- Sparse, inconsistent data collection makes reporting on program quality and impact difficult

Policy Option 1

Request state agencies conduct a review of health care workforce program eligibility, screening criteria, and service requirements

- Identify opportunities to align with Virginia's health care workforce needs based on available supply and demand data
- Report by October 1, 2025, any anticipated changes to program eligibility, screening criteria, and service requirements or barriers to doing so

Policy Option 2

Require VHWDA, in collaboration with Virginia Works, to develop a plan to increase capacity for reporting and monitoring of health care workforce programs. The plan, due October 1, 2025, should consider:

- Maintaining an accurate inventory of health care workforce programs
- Strategies to increase agency capacity for data collection and reporting
- Recommendations for reporting that meet the duties of VHWDA and Virginia Works while balancing the administrative burden of state agencies to report such information

VHWDA = Virginia Health Workforce Development Authority

Member Discussion and Voting

Meeting Agenda

Performance of Health Care Workforce Programs

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Results of Study of Strategies to Extend Health Care Access to Vulnerable Populations

Update on 2025 Study Priorities

Strategies to Extend Health Care Access to Vulnerable Populations

Lead Analysts: Kyu Kang, Estella Obi-Tabot, Emily Atkinson

Study purpose

- Evaluate alternative models for extending health care access, including determining which populations benefit, how services are delivered, and how the costs of services compare to their anticipated benefit
- Identify ways in which peer states support similar models
- Develop policy options through which Virginia may support effective models to extend health care access

Study resolution approved by Commission on December 6, 2023

Access to care is multi-dimensional

Broadly defined across five domains as the ability to obtain appropriate health care services when needed

Access to Care Domains	Mobile Health Clinics	Community Paramedicine	Home Visiting	Community Health Workers	Telehealth
Approachability	X		X	X	
Acceptability	X	X	X	X	
Availability and Accommodation	X	X			X
Affordability	X	X			
Appropriateness			X	X	

SOURCE: Adapted from Levesque, J. F., Harris, M. F., & Russel, G. (2013). Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health, (12),* 18, pp. 1-9.

Populations experience different barriers to health care

- Vulnerable populations have a high risk for health care problems, face significant hardship, or have a limited ability to understand or communicate effectively
- Underserved populations have been systematically denied opportunities to fully participate in health care based on shared characteristics

Strategies to enhance access balance targeted and population approaches

- Targeted strategies provide short-term relief for specific populations, while population-based strategies provide longer-term solutions for broader populations
- Study examines strategies to extend health care access:
  - Mobile health clinics
  - Community paramedicine programs
  - Home visiting programs
  - Community health workers
  - Telehealth

Agenda

Mobile Health Clinics

Community Paramedicine Programs

Home Visiting Programs

Community Health Workers

Telehealth

Mobile health clinics

- **Mobile health clinics or "mobile units"** are vehicles that have been modified to provide space for clinical services inside the vehicle
- Mobile health clinics offer a wide range of services, depending on the organization, service area, patient population, and funding
- Flexibility of the mobile health clinic model allows for quick response to changing community needs

Richmond-Henrico Health District's mobile van has an extendable awning to create more space

SOURCE: Richmond-Henrico Health District, 2024

Mobile health clinics increase patient access to care

- Mobile health clinics are able to:
  - Bring care to areas and populations that may otherwise lack access
  - Remove cost, distance, and administrative barriers
  - Serve patients who would not have otherwise sought care
- They can generate cost savings by providing preventive care and chronic disease management

Mobile opioid treatment can support patients in treatment and recovery

- Medication-Assisted Treatment for opioid use disorder (OUD) requires frequent clinic visits, which can be challenging
- Currently, a handful of mobile health clinics in Virginia provide buprenorphine prescriptions
- Federal guidelines allow opioid treatment programs to deploy mobile units to dispense OUD medications
  - There are no mobile units in Virginia that dispense OUD treatment medications

Policy Option 1

The JCHC could introduce legislation directing 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.

Mobile health clinics with internet access could facilitate telehealth visits

- Reliable internet access allows mobile health clinics to offer an array of health care services
- Telehealth-enabled mobile health clinics can facilitate patient connections to care and serve individuals in health care deserts, particularly rural areas
- DHCD is currently identifying state needs to allocate a portion of federal broadband funding

DHCD = Department of Housing and Community Development

Policy Option 2

The JCHC could introduce legislation directing the Department of Housing and Community Development to include broadband access services for mobile health clinics as a priority for broadband adoption programs using Broadband Equity, Access, and Deployment Program funding.

Mobile health clinic operations are difficult to sustain

- Logistics can be difficult to manage
  - Right-sizing vehicles to match operational needs can be challenging
  - Vehicle maintenance, weather, parking, etc. affect operations
- Staffing requires balancing multiple needs
  - Staff must possess cultural competency and be willing to go into communities, work in small spaces, and travel frequently
  - Qualified providers who can deliver needed services, particularly prescribers, are expensive
- Funding is often inconsistent and revenue generation is unreliable, particularly in rural and underserved areas

Policy Option 3

The JCHC could introduce a budget amendment to establish a grant program administered by the Virginia Department of Health supporting mobile health clinics operated by local health departments and community-based organizations that provide services in rural and underserved areas.

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EMS providers are being utilized in non-traditional roles to expand access

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

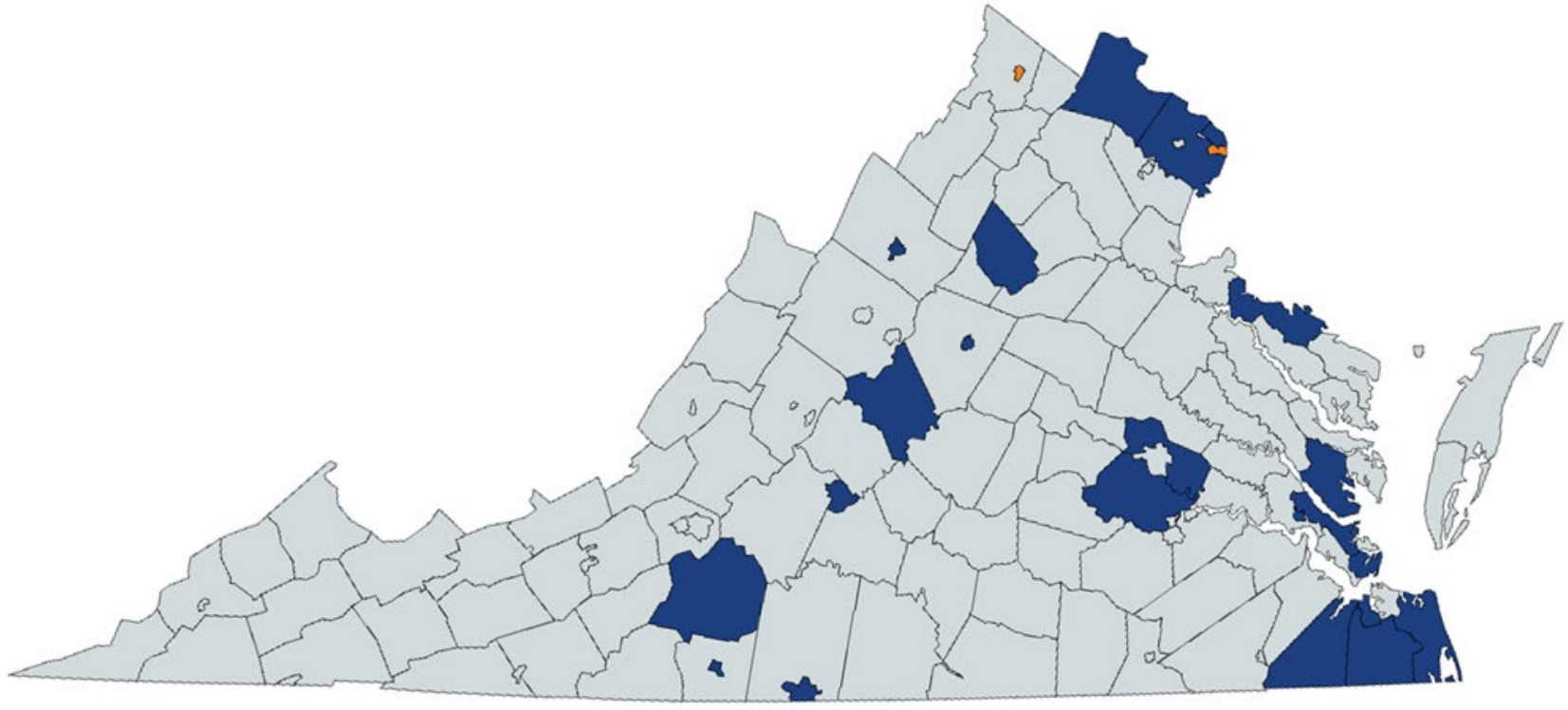
- **Community paramedicine (CP)** programs use paramedics
- **Mobile integrated healthcare (MIH)** programs use multi-disciplinary care teams, which may include emergency medical technicians and paramedics

NOTE: For brevity, this study uses the term "community paramedicine" to refer to both types of programs.
EMS = emergency medical services

Community paramedicine programs support vulnerable populations

- Community paramedicine programs target high-risk or high-needs patients (e.g., frequent 911 calls, high risk of rehospitalization)
- Community paramedicine programs offer different care models to meet community needs, improve patient outcomes, and help reduce utilization and costs
  - Schedule non-emergent home visits
  - Respond to low-acuity 911 calls

Virginia has at least 26 community paramedicine programs



SOURCE: JCHC analysis of OEMS program documents, EMS provider websites, and local news, 2024.
NOTE: Localities in blue indicate the presence of a community paramedicine or mobile integrated healthcare program; localities in orange indicate the presence of more than one program.

Virginia does not currently regulate community paramedicine programs

- OEMS has a voluntary process for reviewing community paramedicine programs
- OEMS draft regulations establish a mandatory review process and clarify scope for community paramedicine programs

OEMS = Office of Emergency Medical Services

Policy Option 4

The JCHC could introduce legislation directing the Virginia Department of Health's Office of Emergency Medical Services to report to the JCHC by October 1, 2025, regarding the status of draft regulations for community paramedicine and mobile integrated healthcare.

Programs expand patient access to care and relieve pressure from EMS systems

- Patients can receive preventive care, primary care, and referral to psychosocial supports
- Programs are proven to significantly reduce:
  - Unnecessary emergency call volume
  - Ambulance transports and emergency department visits
  - Readmission rates
  - Inpatient utilization

Funding and capacity are the largest limiters for community paramedicine

- Cost-effectiveness of community paramedicine is unclear
  - Reduced ED utilization and readmissions generate cost savings for patients, health plans, and hospitals rather than for EMS
- EMS agencies are only reimbursed when patients request 911 emergency services and are transported to the ED
- Community paramedicine programs operate in addition to regular EMS services, so are only possible with extra capacity and resources

ED = emergency department

Policy Option 5

The JCHC could introduce a budget amendment to establish a grant program or expand an existing 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.

Medicaid covers treatment without transport in more than half of states

- HCPCS Code A0998 – treatment without transport – can be applied when EMS providers address patient needs without transporting to the ED
  - Virginia's Medicaid program does not reimburse HCPCS Code A0998
- States can design their own reimbursement models for EMS services
  - Arizona and Washington established "Treat and Refer" programs that qualify for reimbursement

HCPCS = Healthcare Common Procedure Coding System

Policy Option 6

The JCHC could introduce legislation directing the Department of Medical Assistance Services to cover HCPCS Code A0998 treatment without transport when Medicaid patients call 911.

There are multiple models for reimbursing community paramedicine

Reimbursement models may vary based on what kinds of services are being provided:

- Treatment without transport (HCPCS Code A0998)
- Transportation to alternative destinations
- Services ordered by patients' physicians
- Bill for non-emergent services provided at home

Policy Option 7

The JCHC could introduce legislation directing the Department of Medical Assistance Services to work with the Virginia Department of Health's Office of Emergency Medical Services to develop a plan for reimbursing community paramedicine and mobile integrated healthcare services in Virginia.

Additional federal funds may help support general capacity building

- Medicaid reimbursement for EMS is not always sufficient to offset the cost of providing services
- Rural EMS agencies are more likely to serve and transport individuals on Medicaid
- The Ground Emergency Medical Transportation (GEMT) program provides supplemental federal payments to EMS agencies for transporting Medicaid patients

Policy Option 8

The JCHC could introduce legislation directing the Department of Medical Assistance Services to seek approval from the Centers for Medicare and Medicaid Services for implementation of the Ground Emergency Medical Transportation program in Virginia.

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Home visiting supports parents, families, and children up to age 5

- Home visiting supports expectant and new parents, families, and children who are at risk for poor maternal and child outcomes by:
  - Engaging the family to develop a care plan,
  - Providing education to the parent and caregiver, and
  - Connecting families to appropriate services
- All home visiting programs are voluntary and usually offered through local non-profit organizations, health systems, and public agencies

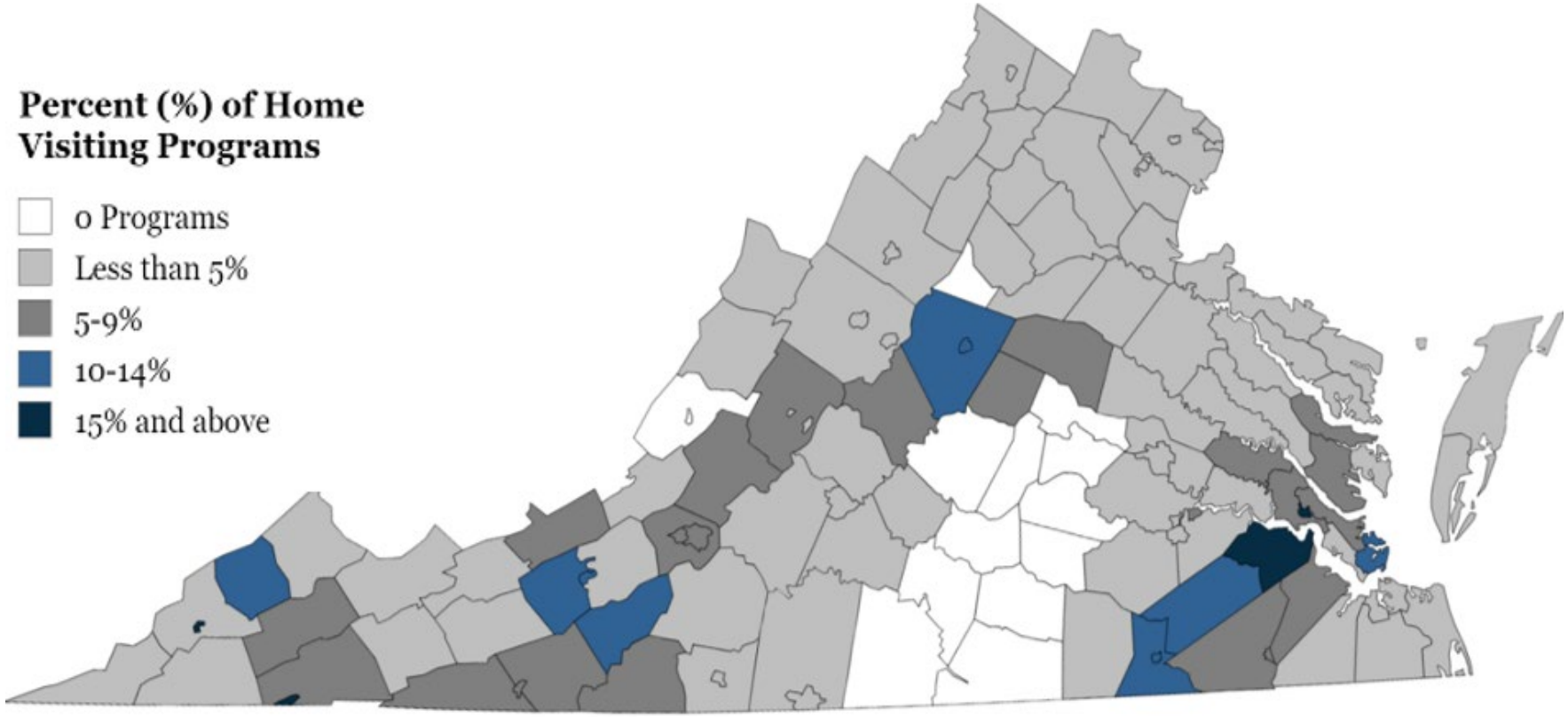
Home visiting improves maternal and child outcomes

- Home visiting programs target social determinants of health and support families outside of the clinical setting
- Home visiting programs are effective for families who experience poverty or mental health challenges as these program increase access to resources
- Home visiting programs are particularly effective in reducing pre-term births and improving maternal and infant health outcomes

Eight home visiting models serve different target populations in Virginia

- Early Impact Virginia oversees Virginia's home visiting programs
- Home visiting models differ with regard to enrollment length, provider type, intended target population, and evidence that supports its effectiveness
- Local organizations consider community needs when determining which home visiting models to implement

Home visiting providers meet less than 5 percent of community need



SOURCE: Early Impact Virginia and JCHC staff review of program documentation, 2024.

Home visiting programs are supported by multiple funding streams

- In FY 2024, overall investment in Virginia's home visiting programs was $36 million with greatest share from federal funding and smallest share from state funding
- Virginia GA appropriated $5.2 million for FY 2025 to address a budget shortfall and meet federal matching requirements
- State investment in home visiting programs increased by 2.4 percent in FY 2025, though this increase is unlikely to expand access to services due to inflation

NOTE: In FY 2024, Virginia received $19.0M in federal funding, $9.1M in local funding, $7.0M in private funding, and $1.0M in state funding. FY = state fiscal year; GA = Virginia General Assembly

Additional home visiting programs could be eligible for federal funding

The MIECHV Program provides funding to states to support evidence-based home visiting services that meet specific criteria

- Three home visiting programs in Virginia currently receive MIECHV program funding
- One home visiting program in Virginia, CHIP of Virginia, could be eligible for MIECHV program funding pending comprehensive review

MIECHV = Maternal, Infant, and Early Childhood Home Visiting

Policy Option 9

The JCHC could introduce a budget amendment to provide funding to Families Forward Virginia to serve a new cohort of parents that will be part of a randomized control trial required to collect evidence to determine whether CHIP of Virginia meets criteria for federal certification as an evidence-based home visiting model.

Medicaid funding could enhance capacity of home visiting services

- 28 states offer a home visiting benefit through their state Medicaid programs
- Most states that cover home visiting services do so through a Medicaid state plan amendment
- Prior to the COVID-19 pandemic, DMAS was directed to develop a home visiting benefit in Virginia

DMAS = Department of Medical Assistance Services

Policy Option 10

The JCHC could introduce legislation directing the Department of Medical Assistance Services to convene a workgroup to develop a plan for a Medicaid home visiting benefit for pregnant and postpartum individuals and their families.

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A community health worker is a frontline public health worker

- A CHW is a trusted member of and has a uniquely close understanding of the community they serve
- CHWs may work under a variety of titles including case managers, peer navigators and outreach specialists
- Virginia allows CHWs to choose whether they pursue optional certification

CHW = community health worker

CHWs work in various settings to fill gaps in health care

- CHWs work in health departments and community-based organizations and for health care providers and payers
- CHWs can:
  - Increase patient health literacy
  - Advocate for individual and community needs
  - Connect individuals to health care and social services
  - Reduce health disparities, particularly in communities of color
  - Promote health equity

Sustainability of CHW workforce is uncertain without consistent funding

- Significant one-time federal investment supported expansion of CHW workforce in Virginia
- In 2024, VDH requested $5.7 million per year to continue funding existing CHW positions at local health districts
  - Virginia General Assembly appropriated $3.2 million per year targeted to positions in areas with high maternal mortality
- Appropriating additional general funds to VDH to support CHWs and removing restrictions on location and function of positions could ensure CHWs remain available to provide a broad array of services

VDH = Virginia Department of Health

Policy Option 11

The JCHC could introduce a budget amendment to provide an additional $2.5 million to the Virginia Department of Health (VDH) to support all remaining community health worker (CHW) positions and remove language requiring VDH to prioritize CHW positions in high maternal mortality areas.

Insight on current CHW workforce could identify funding needs

- As of September 2024, VDH has a total of 130 CHW staff
- An annual comprehensive review of state and local health departments could help VDH monitor capacity and needs for CHWs on an ongoing basis
  - Review could include analysis of performance and outcome measures to understand the impact of CHWs

Policy Option 12

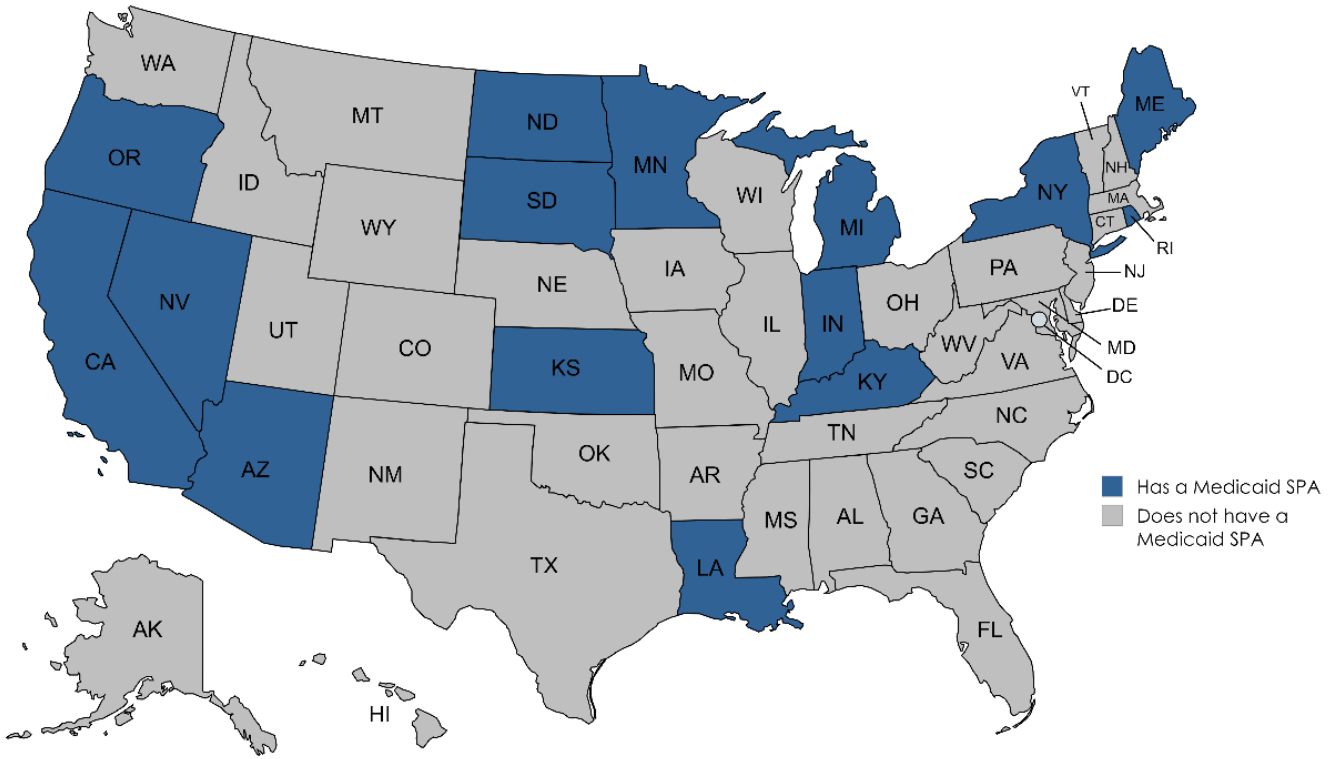
The JCHC could introduce a budget amendment directing the Virginia Department of Health to report annually on:

- Number of community health workers (CHWs) employed within state and local health departments
- Type of services provided and performance and outcome measures for such services
- Need for additional CHWs to meet demand for services
- Success in attracting non-state resources
- Description of contracts entered by localities

Virginia's Medicaid program could provide sustainable funding of CHWs

- 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 also evaluate opportunities for CHWs to become eligible for reimbursement for other services already reimbursed by the state's Medicaid program

Fifteen states authorize coverage of CHW services through Medicaid SPA



SOURCE: JCHC staff analysis of the Association for State and Territorial Health Officials and National Academy of State Health Policy data, 2024. SPA = state plan amendment

Previous legislation has requested a CHW benefit through a Medicaid SPA

- HB 594/SB 615 (2024) would have required the DMAS to convene a workgroup of stakeholders to design a CHW benefit for Virginia's Medicaid program
- Any potential benefit would need to fall within allowable scope under federal guidelines
- Members could revisit this approach to authorize Medicaid reimbursement of CHW services

DMAS = Department of Medical Assistance Services

Policy Option 13

The JCHC could introduce a budget amendment directing the Department of Medical Assistance Services to convene a work group of stakeholders to design a state plan amendment to provide reimbursement for services provided by Certified Community Health Workers.

Virginia could require use of CHWs within existing managed care contracts

- Eleven states use MCO contracts to encourage or require payment of CHW services
- Virginia's Medicaid MCOs utilize CHWs in two ways:
  - As part of required quality improvement activities
  - As part of value-added services available to Medicaid members

MCO = managed care organization

Policy Option 14

The JCHC could introduce a budget amendment directing the Department of Medical Assistance Services to convene a workgroup to identify opportunities to expand use of community health workers by Medicaid managed care organizations.

Flexible certifications could allow CHWs to receive Medicaid reimbursement

- CHW scope of practice includes services similar to some provided by state-certified doulas and registered peer recovery specialists
- Flexible training programs that take into account CHWs' prior training and experience could facilitate cross-certification for CHWs
- Certification as a state-certified doula or registered peer recovery specialists could allow CHWs to receive Medicaid reimbursement for some services

Policy Option 15

The JCHC could introduce legislation directing the Virginia Department of Health to convene a workgroup to determine the feasibility of developing flexible training and certification standards that allow community health workers to use their education and experience to satisfy some of the requirements for qualification as a state-certified doula or registered peer recovery specialist.

Ongoing workforce development could support retention and avoid burnout

- CHWs show trends of leaving their position due to lack of job security created by the short-term or grant funded nature of positions
- CHWs may face limited opportunities for advancement within their field or to move into supervisory positions

CHWs are affected by the same SDOH they address in their role

- CHWs are usually part of the community they serve, often sharing the same ethnicity, language, socioeconomic status, and life experiences as the people to whom they provide services
- In a national sample, CHWs identified the importance of staying connected and receiving support from other CHWs in their field
- Virginia CHW association could provide support to the CHW workforce with funding

SDOH = social determinants of health

Policy Option 16

The JCHC could introduce a budget amendment to provide funding to the Virginia Community Health Worker Association to expand workforce development efforts for community health workers and report annually.

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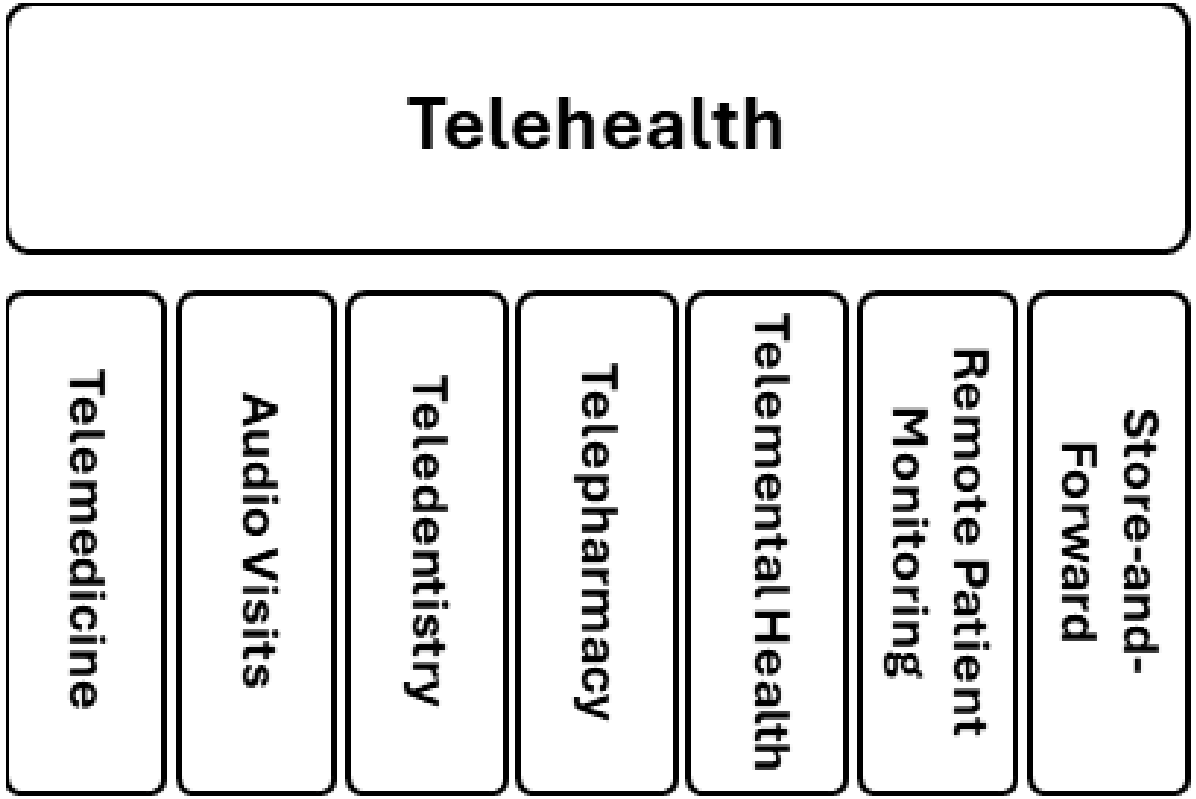
Telehealth facilitates virtual patient-provider interactions



SOURCE: JCHC staff analysis of peer-reviewed literature, 2024

Virginia offers comprehensive telehealth services with few restrictions

Virginia has acted to:

- Ensure coverage and payment parity
- Expand the types of services for which Medicaid reimbursement is available
- Removed restrictions that limit ability of providers to deliver telehealth services in Virginia

Telehealth improves access to care for vulnerable, underserved populations

Telehealth can improve patient access to care by:

- Removing transportation related barriers
- Increasing access to culturally appropriate care
- Improving efficiency of health care practices
- Mitigating the effects of workforce shortages

VDH develops and implements the Virginia Telehealth State Plan

There is no staff member at VDH dedicated to supporting telehealth initiatives resulting in:

- A failure to maintain progress on the Telehealth State Plan
- A lack of provider education on telehealth
- A lack of clarity regarding the status of current telehealth initiatives
- Agency delays in contracting and payments for telehealth activities

VDH = Virginia Department of Health

Lack of provider training creates challenges to telehealth expansion

- Providers in Virginia require additional training and guidance around:
  - Medicaid coverage for telehealth services
  - Telehealth best practices
- Providers require guidance on delivery of telehealth services to individuals with disabilities

Policy Options 17 and 18

The JCHC could introduce a budget amendment to provide funding for a Telehealth Coordinator position at the Virginia Department of Health.

The JCHC could introduce legislation directing the Department of Behavioral Health and Developmental Services to develop best practice training for providers on telehealth visits for patients with disabilities.

Telehealth Access Points could increase access to telehealth services

- Lack of broadband and telehealth technology restricts telehealth services
- Telehealth Access Points (TAPs) are pre-existing community spaces that have the technology and internet infrastructure necessary to support telehealth services
  - Pharmacy Care Hubs are TAPs located in pharmacies
  - Schools can also serve as TAPs

Policy Options 19 and 20

The JCHC could introduce a budget amendment 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.

The JCHC could introduce legislation directing the Virginia Board of Education to require local boards of education to establish policies to facilitate students' access to telehealth services during the school day.

Insufficient reimbursement and gaps in coverage are barriers to telehealth

- A 2024 VTN benching marking survey found:
  - 47.3 percent of respondents agreed that reimbursement is adequate
  - 66.2 percent of respondents identified reimbursement as a top area for improvement of telehealth
- Restrictions on and exclusions from coverage create disincentives and limit access to telehealth services

VTN = Virginia Telehealth Network

Providers frequently use e-consults, but reimbursement is not available

- E-consults are virtual consultations between health care providers
- In the 2024 VTN survey, 56.5 percent of providers reported that synchronous provider-to-provider consultations were the modality of telehealth that they used most frequently
- E-consults were approved for reimbursement through Medicaid during the 2022 legislative session, but the Virginia General Assembly has not appropriated funds

Policy Option 21

The JCHC could introduce a budget amendment to appropriate the funds for e-consults.

Restrictions on Medicaid coverage limit access to remote patient monitoring

- A patient with a chronic condition is eligible for RPM if the patient has visited the ED or been hospitalized two or more times in the last for reasons related to their condition
- Virginia's criteria takes a reactive approach while other states take a more proactive approach, before a medical emergency has occurred

RPM = remote patient monitoring; ED = emergency department

Policy Option 22

The JCHC could introduce legislation directing the Department of Medical Assistance Services to develop a plan and estimate costs for expanding eligibility criteria under Medicaid for remote patient monitoring for individuals with chronic conditions.

Inconsistent coverage for audio-only telephone visits is a barrier

- Stakeholders report frequently using audio-only telephone to provide services to patients who are unable to access other forms of telehealth
- "Audio-only telephone" are explicitly excluded from the definition of "telemedicine" in the Code of Virginia
  - Medicaid has opted to cover audio-only telephone visits
  - Commercial payers may or may not cover

Policy Option 23

The JCHC could introduce legislation removing the exclusion of audio-only telephonic communication from the definition of telemedicine and requiring insurers to cover audio-only telehealth visits to the same extent that they cover other types of telemedicine services in cases in which audio-only telehealth services are clinically appropriate.

Funding for VTMHI could increase access to mental health services

- Research demonstrates that efficacy rates for telemental health visits are similar to rates of in-person mental health services
- Virginia General Assembly provides funding to VTN to implement the Virginia Telemental Health Initiative (VTMHI) which:
  - Expands access to telemental health services in free and charitable clinics
  - Addresses workforce barriers by helping pre-licensed mental health professionals obtain clinical hours to satisfy licensure requirements

Policy Option 24

The JCHC could introduce a budget amendment to increase funding for the Virginia Telemental Health Initiative by $482,000 to increase by 50 percent the number of patients served.

Funding for teledentistry in nursing homes could expand oral health access

- Teledentistry allows a distant-site dentist to provide oral health screenings with the support of an on-site dental or medical care provider
- Teledentistry programs for older adults in nursing homes:
  - Address barriers to oral health care faced by residents of nursing facilities
  - Promote medical-dental integration to enhance whole-person health

Policy Option 25

The JCHC could introduce a budget amendment to provide funding to Virginia Health Catalyst to, in collaboration with the Oral Health Task Force, plan and implement a pilot program to provide teledentistry services in nursing homes.

Telehealth visits could expand access to health care for incarcerated individuals

- VADOC is required to provide inmates with health care services
- In 2018, JLARC found that VADOC "transported inmates for offsite care and back more than 25,000 times at an estimated cost of between $1.3 and $1.6 million for fuel and vehicle maintenance"
- VADOC implemented a telehealth pilot program in 2020 to reduce cost of transporting inmates for health care

VADOC = Virginia Department of Corrections; JLARC = Joint Legislative Audit and Review Commission

Policy Option 26

The JCHC could introduce legislation requiring 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.

Opportunity for public comment

Submit written public comments by close of business on Friday, November 1st

Email: jchcpubliccomments@jchc.virginia.gov

Mail: 411 E. Franklin Street, Suite 505
Richmond, VA 23219

NOTE: All public comments are subject to FOIA and must be released upon request.

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- Update on Public Comment Received
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Update on 2025 Study Priorities

Joint Commission on Health Care

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