BHC recommendations for inclusion in 2026 legislative agenda

Description of recommendation / option Study	Budget amendment / bill language (draft)	Need for legislative action
Implementation and effectiveness of Marcus Alert program		
Recommendation 2 The General Assembly may wish to consider amending § 9.1-193 (H) to change the Code reference from "clause (iv) of subdivision B 2 of § 37.2-311.1", to "clause (vi) of subdivision B 2 of § 37.2-311.1".	**Implemented – Code Commission**	Subsection H of § 9.1-193 contains a typo. The subsection directs localities to implement Marcus Alert Protocol 1 in accordance with the state plan, but it currently references "clause (iv) of subdivision B 2 of § 37.2-311.1"—which pertains to reviewing the prevalence of crisis situations—rather than clause (vi)—the clause that references the implementation of Protocol 1.
Recommendation 4 The General Assembly may wish to consider including $7.8 million in each year of the 2026 Appropriation Act for the remaining thirteen CSBs that have not yet begun their Marcus Alert planning process.	**Budget amendment – Grants to Localities (790)** **Funding: FY27** ~~$16,200,000~~ $24,000,000; **FY28** ~~$16,200,000~~ $24,000,000 **Language:** Out of this appropriation, ~~$16,200,000~~ $24,000,000 the first year and ~~$16,200,000~~ $24,000,000 the second year from the general fund shall be provided to establish mental health awareness response and community understanding services alert system programs and community care teams pursuant to legislation adopted in the 2020 Special Session I of the General Assembly […] **Note:** this amount assumes current funding level of $600,000 per CSB area, on average	The 13 CSBs that have not yet implemented the Marcus Alert system must receive planning funds in FY27 or FY28 in order to meet the July 2028 statutory deadline for statewide Marcus Alert implementation. Most successful Marcus Alert sites received planning grants one year before launching their system.
Recommendation 6 The General Assembly may wish to amend §37.2-311.1 to specify that DBHDS is the agency	**Amend §37.2-311.1 (D)** D. *The Department shall convene the Marcus Alert*	The state plan developed to operationalize the Marcus-David Peters Act charges a Task Force with ongoing monitoring and evaluation of the

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responsible for convening the Marcus Alert Evaluation Task Force and require that the Task Force be convened at least quarterly to design and implement an evaluation process as described in the state plan for Marcus Alert. To provide adequate staffing for this project, the General Assembly may also wish to consider including in the Appropriation Act funding and one position for a Marcus Alert Evaluation Analyst at DBHDS.	*Evaluation Task Force, as described in the written plan developed pursuant to this section, at least semi-annually. Staffing support for the Task Force shall be provided by Department.* *E.* The Department*, in collaboration with the Marcus Alert Evaluation Task Force*, shall report annually by November 15 to the Governor and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services, the Senate Committees for Courts of Justice and on Education and Health, and the Behavioral Health Commission regarding the comprehensive crisis system and the effectiveness of such system in meeting the goals set forth in this section[…]	Marcus Alert system. However, the Task Force has never met, in part because no agency is responsible for making sure the Task Force is playing its intended role. To ensure the system's long-term success, the state must develop robust outcome measures and a process to evaluate performance on these measures.
	Budget amendment – Department of Behavioral Health and Developmental Services **Funding: FY27** $150,000; **FY28** $150,000 **FTE: FY27** +1.0 **Language:** Of the amounts appropriated in [Item TBD], $150,000 the first year and $150,000 the second year from the general fund shall be used to support a Marcus Alert evaluation analyst on a full-time basis.	The Marcus Alert Evaluation Task Force will need ongoing data collection and analysis to measure system performance. A dedicated staff position within DBHDS will be required to support this work, because no existing position at the agency has either the expertise or the time to absorb these new responsibilities.
Option 1 The General Assembly may wish to consider amending the budget language related to Marcus Alert implementation to remove the fixed $600,000 allocation per CSB, grant DBHDS discretion to distribute available Marcus Alert funds based on the needs of each community, and stipulate that	**Budget amendment – Grants to Localities (790)** **Language:** Delete ~~*Each local or regional implementation area program shall receive $600,000 each year for this purpose.*~~	Each CSB receives $600K per year for Marcus Alert regardless of size, needs, or fiscal situation. Equal funding across CSBs does not accommodate the variation that exists in implementation decisions (e.g., CSBs that choose not to create a co-response team may not need $600K).

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funding must be provided to PSAPs for necessary system updates, training, and related expenses.		
Option 2 The General Assembly may wish to amend § 15.2-1726 to include co-response teams with jurisdiction in multiple localities as an acceptable reciprocal agreement between law enforcement agencies.	**Amend § 15.2-1726** 'Any locality may, in its discretion, enter into a reciprocal agreement with any other locality, any agency of the federal government exercising police powers, the police of any public institution of higher education in the Commonwealth appointed pursuant to subsection B of § 23.1-812, the Division of Capitol Police, any private police department certified by the Department of Criminal Justice Services, or any combination of the foregoing, for such periods and under such conditions as the contracting parties deem advisable, for cooperation in the furnishing of police services. Such agreements may include *(i)* designation of mutually agreed-upon boundary lines between contiguous localities for purposes of organizing 911 dispatch and response and clarifying issues related to coverage under workers' compensation and risk management laws*; (ii)* ~~. Such agreements may also include~~ provisions allowing for the loan of unmarked police vehicles*; or (iii) development of co-response teams staffed by one or more law enforcement agencies that respond to behavioral health-related calls in multiple jurisdictions.* […]'	Having one co-response team in every jurisdiction may be inefficient, especially for small law enforcement agencies and small jurisdictions that may not have enough need on their own to justify a team. One solution to this is multi-jurisdictional co-response teams, which currently exist in a few localities. A barrier to creating more multi-jurisdictional co-response teams is that some law enforcement agencies are uncertain about the legality of multi-departmental co-response efforts. This option would clarify in statute that co-response is an acceptable form of inter-agency agreement between law enforcement agencies.
Option 3 The General Assembly may wish to consider funding and directing DBHDS to establish two pilot programs available to localities that have implemented the Marcus Alert system. The purpose of these respective pilots would be: (1) developing or expanding the capacity of	**Budget amendment – Department of Behavioral Health and Developmental Services** **Funding:** See note below **Language:** Of the amounts appropriated in [Item TBD], [Amount TBD] the first year and [Amount TBD] the second year from the general fund shall be used to	A large portion of Virginia's behavioral health crisis calls go to 911 call centers, but they currently have no ability to dispatch behavioral health-only mobile crisis response (MCR) teams. As a result, individuals in crisis frequently receive a response from law enforcement when they could have been better served by MCR. There

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CSB behavioral health-only teams that can be dispatched by PSAPs; and (2) embedding regional mobile crisis dispatchers and optionally, clinicians, in PSAPs.	establish and implement a pilot program to enable 9-1-1 dispatch of regional mobile crisis teams. This pilot shall include at least one site for each of the following dispatch models: a) regional mobile crisis dispatchers embedded in public safety answering points; and b) 9-1-1 telecommunicators trained in using the Virginia Crisis Connect system for the purpose of dispatching regional mobile crisis. Each of the pilot sites shall include the establishment and operationalization of policies and procedures for dispatching regional mobile crisis teams to Marcus Alert Level 3 calls when no imminent public safety risk exists. The Department shall evaluate the effectiveness of both models at diverting 9-1-1 calls from law enforcement and the cost-effectiveness of both models and shall report to the Behavioral Health Commission on the outcomes from all pilot sites by November 1, 2027. **Note:** There are several levels of investment that members could choose for the pilot program. Model A embeds trained regional mobile crisis team dispatchers in 911 call centers, and Model B trains 911 dispatchers to use specialized software to dispatch mobile crisis teams themselves: ▪ $240,000- Model B only, two sites total (one urban, one rural) ▪ $760,000- Model A (one urban site) and Model B (one rural site) ▪ $1.2M- Model A only, two sites total (one urban, one rural) ▪ $1.4M- Model A and Model B, four sites total (two urban, two rural) This recommendation will be combined with Option 1	are several methods for MCR to be integrated with 911; testing these methods in a limited pilot would yield efficacy data to inform future funding decisions.

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	from the "Aligning crisis services and the civil commitment process" study, which requires a pilot program that can be an extension of the pilot for this option.	
Option 4 The General Assembly may wish to consider including in the 2026 Appropriation Act one additional FTE and funding to support hiring one Co-response Coordinator at the Department of Criminal Justice Services (DCJS).	**Budget amendment – Department of Criminal Justice Services** **Funding: FY27** $125,000; **FY28** $125,000 **FTE: FY27** +1.0 **Language:** Of the amounts appropriated in [Item TBD], $125,000 the first year and $125,000 the second year from the general fund shall be used to support one co-response coordinator on a full-time basis.	Co-response teams in Virginia vary widely in terms of their composition, hours, policies, and practices, and there is limited state guidance or oversight to ensure they maximize their potential for diverting individuals from the criminal justice system. Limited data exists on their effectiveness and the practices that yield better outcomes. Two-thirds of localities have not yet implemented Marcus Alert, so there will likely be many new co-response teams forming in the next two years. These teams, in addition to existing teams, may benefit from guidance, including information on best practices and on variations in co-response practices across the state.
Option 5 The General Assembly may wish to amend § 9.1-193 to transfer responsibility for initiating profile deletion within the database from PSAPs to individuals.	**Amend § 9.1-193 (F)** 'F. By July 1, 2023, every locality shall establish a voluntary database to be made available to the 9-1-1 alert system and the Marcus alert system to provide relevant mental health information and emergency contact information for appropriate response to an emergency or crisis. Identifying and health information concerning behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury may be voluntarily provided to the database by the individual with the behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury; the parent or legal guardian of such	Statute requires PSAPs to delete a child's profile from the local Marcus Alert database when they turn 18. Many PSAPs rely on third-party platforms to develop a voluntary database of people with behavioral health needs, in accordance with statute. However, PSAPs have no power to delete an individual's profile from these external platforms: only the person who made the profile can delete the information. Some PSAPs are therefore concerned that they may be unintentionally out of compliance with the law.

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	individual if the individual is under the age of 18; or a person appointed the guardian of such person as defined in § 64.2-2000. An individual shall be removed from the database when he reaches the age of 18, unless he or his guardian, as defined in § 64.2-2000, requests that the individual remain in the database, *or the individual's information is maintained on an external database that cannot be directly accessed by the locality*. Information provided to the database shall not be used for any other purpose except as set forth in this subsection. **Note:** Language changed to reflect Del. Obenshain's suggestion that PSAPs remain responsible for purging records they can access on local databases. PSAPs are unable to notify individuals who use third-party platforms of their rights, because these platforms do not allow PSAPs to have a list of users in their locality, for privacy reasons.	
Option 6 The General Assembly may wish to consider amending §37.2-311.1 to specify that DBHDS and DCJS have authority to update the "written plan for the development of a Marcus Alert system," provided that stakeholders are afforded an opportunity to provide input before updates are finalized**.**	**Amend §37.2-311.1 (2)** 2. By July 1, 2021, the Department, in collaboration with the Department of Criminal Justice Services and law-enforcement, mental health, behavioral health, developmental services, emergency management, brain injury, and racial equity stakeholders, shall develop a written plan for the development of a Marcus alert system. Such plan shall (i) inventory past and current crisis intervention teams established pursuant to Article 13 (§ 9.1-187 et seq.) of Chapter 1 of Title 9.1 throughout the Commonwealth that have received state funding; (ii) inventory the existence, status, and experiences of community services board mobile crisis	The state plan for Marcus Alert was completed in 2021 and may need updates to reflect the evolving nature of the crisis system as well as best practices that have emerged. DBHDS and DCJS lack explicit authority to update the plan, which has led to uncertainty among agency staff. Giving these agencies the ability to make necessary updates would allow Marcus Alert to grow alongside the crisis system and the development of best practices.

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	teams and crisis stabilization units; (iii) identify any other existing cooperative relationships between community services boards and law-enforcement agencies; (iv) review the prevalence of crisis situations involving mental illness or substance abuse, or both, including individuals experiencing a behavioral health crisis that is secondary to mental illness, substance abuse, developmental or intellectual disability, brain injury, or any combination thereof; (v) identify state and local funding of emergency and crisis services; (vi) include protocols to divert calls from the 9-1-1 dispatch and response system to a crisis call center for risk assessment and engagement, including assessment for mobile crisis or community care team dispatch; (vii) include protocols for local law-enforcement agencies to enter into memorandums of agreement with mobile crisis response providers regarding requests for law-enforcement backup during a mobile crisis or community care team response; (viii) develop minimum standards, best practices, and a system for the review and approval of protocols for law-enforcement participation in the Marcus alert system set forth in § 9.1-193; (ix) assign specific responsibilities, duties, and authorities among responsible state and local entities; and (x) assess the effectiveness of a locality's or area's plan for community involvement, including engaging with and providing services to historically economically disadvantaged communities, training, and therapeutic response alternatives. *The Department, in collaboration with the Department of Criminal Justice Services, may amend the written plan after its publication, provided that the stakeholders listed in this section have been consulted during the development of new language and*	

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	that there has been a public comment period of no less than 30 days prior to the finalization of a new written plan.	
Aligning crisis services and the civil commitment process		
Option 1 The General Assembly may wish to include funding and language in the 2026-2028 Appropriation Act for pilot programs that would enable regional mobile crisis response (MCR) teams to be dispatched from 911 call centers to individuals who are at high risk of coming under an ECO but who do not present an imminent public safety risk (Level 3), using various approaches.	**Budget amendment – Department of Behavioral Health and Developmental Services** **Funding:** See note below **Language:** Of the amounts appropriated in [Item TBD], [Amount TBD] the first year and [Amount TBD] the second year from the general fund shall be used to establish and implement a pilot program to enable 9-1-1 dispatch of regional mobile crisis teams. This pilot shall include at least one site for each of the following dispatch models: a) regional mobile crisis dispatchers embedded in public safety answering points; and b) 9-1-1 telecommunicators trained in using the Virginia Crisis Connect system for the purpose of dispatching regional mobile crisis. Each of the pilot sites shall include the establishment and operationalization of policies and procedures for dispatching regional mobile crisis teams to Marcus Alert Level 3 calls when no imminent public safety risk exists. The Department shall evaluate the effectiveness of both models at diverting 9-1-1 calls from law enforcement and the cost-effectiveness of both models and shall report to the Behavioral Health Commission on the outcomes from all pilot sites by November 1, 2027. **Note:** There are several levels of investment that members could choose for the pilot program. Model A embeds trained regional mobile crisis team dispatchers	Most individuals who meet Level 3 criteria call 911 during a crisis but only about 2 percent receive a response from behavioral health-only teams, the preferred response when there is no imminent risk to public safety. 911 call centers are not allowed to dispatch the over 100 MCR teams built as part of the Virginia's crisis system expansion, and few exist outside of MCRs. A pilot project will help test several methods for dispatching MCR teams from 911 to individuals who meet Level 3 criteria, before adopting a statewide solution.

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	in 911 call centers, and Model B trains 911 dispatchers to use specialized software to dispatch mobile crisis teams themselves: ▪ $240,000- Model B only, two sites total (one urban, one rural) ▪ $760,000- Model A (one urban site) and Model B (one rural site) ▪ $1.2M- Model A only, two sites total (one urban, one rural) ▪ $1.4M- Model A and Model B, four sites total (two urban, two rural) This recommendation will be combined with Option 3 from the "Implementation and effectiveness of Marcus Alert program" study, which includes a pilot program to enable 9-1-1 call centers to dispatch regional mobile crisis teams.	
Option 2 The General Assembly may wish to include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing the HHR Secretary to identify the regulatory, billing, or training changes required to enable regional mobile crisis response teams to be dispatched based on calls from third parties (e.g., family members, concerned citizens).	**Budget amendment – Secretary of Health and Human Resources** **Language:** The Secretary of Health and Human Resources, in collaboration with the Department of Medical Assistance Services (DMAS), the Department of Behavioral Health and Developmental Services (DBHDS), CSBs, and regional hubs, shall identify and evaluate any regulatory, billing, training, operational, or other changes necessary to enable CSB regional mobile crisis response teams to be dispatched to individuals in crisis based on calls from third-party callers, including family members and concerned citizens. In conducting such evaluation, the Secretary shall: (i) identify current policies, regulations, and operational protocols that govern regional mobile crisis dispatch,	Regional mobile crisis teams are rarely dispatched in response to calls from third parties, which are disproportionately made on behalf of individuals who meet Level 3 criteria. These individuals therefore do not receive in-person services they may need and may deteriorate. It is unclear whether third-party dispatch is allowed based on the large volume of statutory, regulatory, and administrative requirements at the state and federal levels. However, some other states appear to dispatch mobile crisis response teams based on third-party referrals.

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	including any provisions that limit dispatch to situations in which verbal consent is obtained directly from the individual in crisis; (ii) assess what regulatory or legal changes would be required to authorize dispatch in circumstances in which the individual in crisis is unable or unwilling to verbally consent; (iii) evaluate the billing, reimbursement, and funding implications associated with expanded dispatch authority, including any changes needed to Medicaid or other payer policies; and (iv) examine workforce, training, safety, and operational considerations necessary to support safe and effective responses to third-party calls requesting mobile crisis intervention. The Secretary, or a designee, shall submit a report of the findings and recommendations to the Behavioral Health Commission no later than December 1, 2026.	
Option 3 The General Assembly may wish to include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing DBHDS to identify strategies to serve more individual subject to an ECO or TDO in crisis facilities by incentivizing existing CRCs and CSUs to follow no-barrier approach and to offer a rapid drop-off option for law enforcement	**Budget amendment – Department of Behavioral Health and Developmental Services** **Language:** The Department of Behavioral Health and Developmental Services (DBHDS) shall identify strategies to incentivize existing Crisis Receiving Centers (CRCs) and Crisis Stabilization Units (CSUs) to serve individuals subject to an Emergency Custody Order (ECO) or Temporary Detention Order (TDO). In conducting such evaluation, DBHDS shall consider what changes to training, staffing, infrastructure, operational protocols, or other factors may be necessary to support an expansion of existing facilities' ability to serve individuals under an ECO or TDO by modeling a "no-barrier" approach to crisis services. For purposes of this evaluation, "no-barrier"	No-barrier facilities are an essential strategy to maximizing diversion from the civil commitment process for individuals who are experiencing an acute behavior health crisis. A low proportion of individuals in Virginia CRCs (3%) and CSUs (11%) were under an ECO or TDO in FY25. Only one crisis facility in Virginia follows the no-barrier model and accepts all individuals, including involuntary and high acuity patients, while offering rapid drop-0off to law enforcement officers.

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	facilities should be able to support rapid law-enforcement drop-off of ECO and TDO individuals; admit individuals regardless of voluntary or involuntary status; safely serve individuals with high-acuity symptoms, including those exhibiting aggressive behaviors; and provide medical clearance for most individuals. No-barrier facilities may include a Crisis Intervention Team Assessment Center as part of their operation but must be capable of admitting individuals under an ECO or TDO directly to their CRC or CSU. In conducting this evaluation, DBHDS shall: (i) assess the extent to which existing CRCs and CSUs can be retrofitted or modified to safely adopt a no-barrier approach to crisis services; (ii) estimate the cost of retrofitting or upgrading existing facilities compared to building new facilities capable of supporting a no-barrier model; (iii) evaluate the need for additional personnel and/or enhanced staff training required to safely operate a no-barrier facility; (iv) estimate the cost of any required staffing increases or training enhancements; (v) estimate the number of ECOs and TDOs that could be appropriately served in CRCs and CSUs operating under a no-barrier model; and (vi) determine the additional capacity that would be required to safely and appropriately serve ECO and TDO individuals while maintaining adequate access for voluntary patients. DBHDS shall submit its findings and recommendations to the Behavioral Health Commission no later than December 1, 2026.	

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STEP-VA performance and evaluation		
Recommendation 1 The General Assembly may wish to consider appropriating STEP-VA funding as one amount rather than setting out appropriations for each STEP, beginning with the 2026-2028 Appropriation Act.	**Budget amendment – Department of Behavioral Health and Developmental Services** **Language:** KK.1. Out of this appropriation, [Total Amount, $ TBD] the first year and [Total Amount, $ TBD] the second year from the general fund and [Amount TBD] the first year and [Amount TBD] the second year from the Crisis Call Center Fund is provided for services by Community Services Boards and Behavioral Health Authorities pursuant to the System Transformation, Excellence and Performance in Virginia (STEP-VA) process and Chapters 607 and 683, 2017 Acts of Assembly. ~~2. Of the amounts in KK.1., $13,134,321 the first year and $13,134,321 the second year from the general fund is provided for same day access to mental health screening services.~~ ~~3. Of the amounts in KK.1., $9,051,734 the first year and $9,051,734 the second year from the general fund is provided for primary care outpatient screening services.~~ ~~4. Of the amounts in KK.1., $27,855,453 the first year and $27,855,453 the second year from the general fund is provided for outpatient mental health and substance use services.~~ ~~5. Out of the amounts in KK.1., $2,000,000 the first year and $2,000,000 the second year from the general fund is provided for crisis detoxification services.~~	DBHDS and CSBs currently lack flexibility to reallocate funds among STEPs because the Appropriation Act sets out funding for each STEP. Providing a single pool of funds would allow DBHDS and CSBs to direct resources where they are most needed. The STEP-specific funding structure was useful to accommodate the program's phased implementation, but it now limits the ability of the state and CSBs to respond to changing community needs and to address capacity gaps.

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	~~6. Out of the amounts in KK.1., $28,730,139 the first year and $28,730,139 the second year from the general fund is provided for crisis services for individuals with mental health or substance use disorders.~~ ~~7. Out of the amounts in KK.1., $4,242,364 the first year and $4,242,364 the second year from the general fund is provided for military and veterans services.~~ ~~8. Out of the amounts in KK.1., $5,814,558 the first year and $5,814,558 the second year from the general fund is provided for peer support and family services.~~ ~~9. Out of the amounts in KK.1., $10,962,375 the first year and $10,962,375 the second year from the general fund is provided for the ancillary costs of expanding services at Community Services Boards and Behavioral Health Authorities.~~ ~~10. Out of the amounts in KK.1., $2,697,020 the second year from the~~ general fund and ~~$10,150,818 the first year and $7,453,798 the second year from the Crisis Call Center Fund is provided for crisis call center dispatch staff.~~ ~~11. Out of the amounts in KK.1., $3,970,250 the first year and $3,970,250 second year from the general fund is provided for psychiatric rehabilitation services.~~ ~~12. Out of the amounts in KK.1., $6,844,427 the first year and $6,844,427 the second year from the general fund is provided for care coordination services.~~ ~~13. Out of the amounts in KK.1., $4,259,924 the first year and $4,259,924 the second year from the general fund is provided for STEP-VA-specific case management services.~~	

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	~~14. Out of the amounts in KK.1., $937,300 the first year and $937,300 the second year from the general fund is provided for regional management of STEP-VA services.~~ ~~15. Out of the amounts in KK.1. $5,190,000 the first year and $5,190,000 the second year from the general fund is provided for grants to Community Services Boards for the cost of transitioning data systems and clinical processes.~~	
Options 1 & 5 The General Assembly may wish to consider including language in the 2026-2028 Appropriation Act directing the Secretary of HHR to convene a taskforce to (i) develop a proposed strategic vision for STEP-VA, and (ii) develop a process for a statewide and CSB-level needs assessments to be conducted. The General Assembly may also wish to consider including $2 million in the first year of the 2026-2028 Appropriation Act for the task force to support a statewide and CSB-level comprehensive needs assessments for services included in STEP-VA.	**Budget amendment – Secretary of Health and Human Resources** **Funding:** FY27 $2,000,000; FY28 $0 **Language:** The Secretary of Health and Human Resources shall convene a taskforce to develop a proposed strategic vision for STEP-VA. The taskforce shall at a minimum include representatives from the Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards (CSBs), Virginia Association of Community-Based Providers, and the Department of Medical Assistance Services (DMAS), and shall report the proposed strategic vision to the Behavioral Health Commission (BHC) for legislative input by July 1, 2027, with a progress update by November 1, 2026. The Secretary shall facilitate a process for incorporating public input into the strategic vision adopted by the BHC and make a final proposal available to the BHC no later than November 1, 2027. The task force shall also develop a process to conduct statewide and CSB-level comprehensive needs assessments no later than November 1, 2026. To	Virginia statute does not provide a long-term vision for the program, only requiring that the nine core STEPs exist at every CSBs. This lack of direction has created confusion among stakeholders about what STEP-VA should accomplish, how success should be measured, and how to prioritize funding going forward. A clear legislative vision would help align objectives, improve strategic planning, and provide direction on expectations. The task force's proposed vision would be reported to the BHC for legislative input and would be revised to incorporate legislative and public input. Virginia lacks a robust assessment of need for STEP-VA services across the state. Without a baseline estimate of community need, it is impossible to determine whether STEP-VA is effectively reducing gaps in behavioral health care, whether current funding levels are adequate, or how to optimize allocation among STEPs and CSBs. The needs assessments would help identify system-level issues and barriers,

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	conduct these needs assessments, $2,000,000 is appropriated in FY27, and any unspent funds at the end of the fiscal year may be carried over to FY28 for the identified purpose. The needs assessments shall be conducted by a third-party and include all information needed to understand unmet need for behavioral health care in Virginia and fulfill the requirements of the CCBHC state needs assessment and community need assessments. The task force shall convene a team to draft a Request for Proposal (RFP) from third-party entities qualified to undertake a needs assessment of this magnitude; outline the scope and deliverable expected from the vendor; and review and select the winning proposal. The team should have equal representation between CSBs and DBHDS and include representatives from DMAS, and other relevant stakeholders. The needs assessments shall be completed and its findings reported to the Behavioral Health Commission no later than October 1, 2027.	determine the need for additional infrastructure and resources, and fulfill CCBHC certification requirements, if pursued.
Option 3 The General Assembly may wish to consider including language in the 2026-2028 Appropriation Act including language in the 2026-2028 Appropriation Act directing DBHDS and DMAS to assist a representative sample of CSBs with conducting an analysis of their Medicaid revenue.	**Budget amendment – Department of Behavioral Health and Developmental Services** **Language:** The Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Department of Medical Assistance Services (DMAS), shall assist a representative sample of Community Services Boards (CSBs) with conducting an analysis of their Medicaid revenue. In conducting this analysis, DBHDS, DMAS, and CSBs shall examine enrollment in Medicaid compared to eligibility, Managed Care Organization denial rates; time spent on billing, Medicaid losses experienced on STEP-VA services, and collections from patients, as well as the	Some CSBs have struggled to maximize Medicaid revenue due to the laborious and complex process for filing claims, duplicative training, credentialing delays, and high denial rates among others. Since FY17, Medicaid revenue per visit has increased by 17 percent, whereas the cost of a visit increased by 64% and other funding sources increased by 66%. Medicaid leverages federal matching dollars and therefore reduces reliance on state and local funds. An in-depth analysis would help identify specific obstacles that hinder CSBs from maximizing Medicaid revenue.

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	primary factors driving results from the analysis. DBHDS and DMAS shall work with CSBs to create an action plan that identifies the changes needed to maximize Medicaid revenue, how changes will be implemented, and on what timeline. DMAS shall complete and communicate the action plan to the Behavioral Health Commission by December 1, 2026.	
Option 4 The General Assembly may wish to consider including language in the 2026-2028 Appropriation Act including language in the 2026-2028 Appropriation Act directing DMAS to identify the specific steps necessary to transition to a prospective payment system (PPS) and its fiscal impact.	**Budget amendment – Department of Behavioral Health and Developmental Services** **Language:** The Department of Medical Assistance Services (DMAS) shall (i) identify the steps necessary for Virginia to effectively and efficiently transition to a prospective payment system (PPS) as required to fully adopt the CCBHC model, (ii) estimate any fiscal impact to the state and to Community Services Boards (CSBs), and (iii) report findings to the House Appropriations Committee, the Senate Finance and Appropriations Committee, and the Behavioral Health Commission by December 1, 2026. As part of this report, DMAS shall estimate a timeframe for transitioning to PPS and examine the actions needed with respect to rate-setting; approval process from the Centers for Medicare and Medicaid Services; Managed Care Organization (MCO) contract modifications; electronic health records and billing system updates; and any other necessary changes. DMAS shall also identify ways to reduce the billing and reimbursement challenges that have been experienced by CSBs under the current Medicaid model.	Virginia has been moving toward CCBHC requirements and quality standards without adopting the PPS financing mechanism designed to sustain the incremental costs of the model. Virginia has opted not to formally pursue CCBHC certification in 2017 and again in 2023 due to the expected fiscal impact of shifting to PPS. Understanding the steps, timeline, and up-to-date fiscal impact of transitioning to PPS would help inform decisions about the state's adoption of the CCBHC model.

Member recommendation

Description of recommendation / option Study	Budget amendment / bill language (draft)	Need for legislative action
Local match of CSB state funding		
The General Assembly may wish to consider including language in the 2026-2028 Appropriation Act directing the Department of Behavioral Health and Developmental Services to examine alternatives to the current 10% local match requirement for CSBs and to report back to the BHC with recommendations.	**Budget amendment – Department of Behavioral Health and Developmental Services** **Language:** The Department of Behavioral Health and Developmental Services (DBHDS) shall examine alternatives to the current 10% local match requirement created by §37.2-509 and §37.2-611 and report to the Behavioral Health Commission by November 1, 2026 with recommendations for: i) a formula for calculating the required annual local match amount, which accounts for regional funds; the timing mismatch between state and local budgeting; and the variation in localities' fiscal situations; ii) a standardized formula for dividing contributions between localities within a multi-jurisdictional CSB; iii) enforcement mechanisms to be used by DBHDS or other state entities when the required match is not met by a locality; and (iv) an estimate of the budget impact of adopting the Department's recommendations on the state and local governments. **Note: BHC members have not yet voted on this policy proposal.**	During the November 2025 briefing on the local match of CSB state funding, BHC members expressed an interest in replacing the current 10% local match requirement with a new formula that accounts for localities' different abilities to collect revenue and to contribute to their CSBs. DBHDS is well-positioned to make recommendations on a new formula and on enforcement mechanisms for ensuring that localities contribute their required match.