BHC report
options and recommendations

Commission members vote on study options and recommendations to establish BHC legislative agenda for upcoming session

- 2026 reports include options and recommendations for members' consideration
  - Substance use services and supports in Virginia schools
  - Enhancement of Medicaid behavioral health services
  - Behavioral health services in Virginia jails
- Report options and recommendations that receive support from majority of members become BHC recommendations
- BHC recommendations are carried by BHC member during 2027 legislative session as bill or budget amendment
  - Patrons will be assigned after the meeting

Proposed process for review of options and recommendations and vote

- Staff provide an overview of each option and recommendation from 2026 reports
  - Past BHC recommendations that failed can be re-introduced
- Stop after each report for member discussion
- Members vote after discussion
  - Vote on ALL report options & recommendations in a block, unless members request specific items to be pulled out

In this presentation

2026 studies

Recommendations from past studies

Substance use services and supports study recommendations would help expand local capacity

1	**Prioritize restorative practices**	Prioritize restorative interventions over suspensions in response to drug infractions at school
2	**Provide centralized support**	Build centralized support structure at VDOE to vet effective programs and practices and provide technical assistance
3	**Assess needs for local staff and funds**	Conduct detailed needs assessment to determine how best to target funding to schools and divisions Conduct biennial behavioral health survey of school divisions

Substance use services and supports in Virginia schools

Prioritize restorative practices

- **Recommendation 1:** Amend §22.1-279.6:1(B) to remove the exception for drug offenses listed in §22.1-777-08 from the requirement that no public elementary or secondary school student shall be suspended, expelled, or excluded from attendance at school unless the school first considers at least one restorative disciplinary practice.
- **Explanation:** Suspensions are harmful to students and fail to address the root causes of substance use. §22.1-279.6:1(B) requires schools to consider restorative practices before using exclusionary discipline, but carves out an exception for cannabis and controlled substances. Because this carveout does not apply to alcohol, tobacco, or nicotine vapes, it creates confusing, inconsistent standards across substances and may deny early supportive intervention to students who need treatment.

Substance use services and supports in Virginia schools

Provide centralized support

- **Recommendation 2:** Include language and funding for 1 FTE in the 2027 Appropriation Act for VDOE to establish a centralized support structure within the Office of Behavioral Health and Student Safety to provide school divisions with technical assistance, training, and a clearinghouse of research-based substance use prevention, intervention, and restorative practices.
- **Explanation:** Some school divisions, especially smaller or underfunded ones, lack the administrative bandwidth to independently evaluate and implement effective programs and practices. A centralized hub maintained by VDOE would help relieve this burden by equipping local staff with vetted resources, implementation toolkits, and guidance for strengthening prevention and early intervention efforts, and establishing community partnerships. Estimated funding needed for 1 FTE is $120K.

Substance use services and supports in Virginia schools

Assess local needs for staff and funds

- **Recommendation 3:** Include language in the 2027 Appropriation Act directing VDOE to conduct a comprehensive statewide needs assessment to determine the staffing needs, estimated costs, recommended staffing ratios, and funding formulas for school-based substance use services, including the need for and feasibility of co-locating Community Services Board clinicians in schools.
- **Explanation:** School divisions require additional staff and funding to perform the on-site activities needed to offer comprehensive and effective substance use supports and services. School divisions' needs vary substantially because of differences in local funding, staffing capacity, community norms, and geography. A statewide assessment would provide the detailed cost estimates and operational data needed by the state to target future funding effectively.

Substance use services and supports in Virginia schools

Assess local needs for staff and funds

- **Recommendation 4:** Include language in the 2027 Appropriation Act directing VDOE to survey each LEA[1] biennially, beginning in 2028, to determine what school-based mental health and substance use services and supports are available, and how schools facilitate access to community providers of mental health and substance use treatment and services.
- **Explanation:** A biennial survey of LEAs to assess how services are being provided in schools and how schools are coordinating with community partners will allow VDOE to continually monitor and evaluate the extent to which students' needs for mental health and substance use services and supports are being met.

[1]LEA – local education agency

Project BRAVO recommendations would improve utilization of services, strengthen crisis oversight, and ensure effectiveness

1	**Increase utilization of underused services**	Fund training for more MST[1] and FFT[1] teams
2	**Curb improper use of crisis services**	Link crisis data across state agencies, MCOs[1], and CSBs[1] Strengthen licensing regulations for crisis services
3	**Measure effectiveness of services**	Fund EBP[1] fidelity assessment Require delivery and outcome reporting for ALL redesigned services

[1]MST – multi-systemic therapy, FFT – functional family therapy, MCOs – managed care organizations; CSBs – Community Services Boards, EBP – evidence-based practice

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[1]MST – multi-systemic therapy, FFT – functional family therapy, MCOs – managed care organizations; CSBs – Community Services Boards, EBP – evidence-based practice

Project BRAVO

Increase utilization of underused services

- **Recommendation 1:** Include funding in the 2027 Appropriation Act for CEP-Va[1] to establish additional MST[1] and FFT[1] teams.
- **Explanation:** MST and FFT utilization remains well below projections because few providers exist and start-up is costly. Nine new teams want to start in FY27, but CEP-Va's[1] budget cannot cover the $565,000 training cost. CEP-Va estimates $590,000 per year would meet provider demand.

[1]CEP-Va – Center for Evidence-based Partnerships in Virginia, MST – multi-systemic therapy, FFT – functional family therapy

Project BRAVO recommendations would improve utilization of services, strengthen crisis oversight, and ensure effectiveness

1	**Increase utilization of underused services**	Fund training for more MST[1] and FFT teams[1]
2	**Curb improper use of crisis services**	Link crisis data across state agencies, MCOs[1], and CSBs[1] Strengthen licensing regulations for crisis services
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[1]MST – multi-systemic therapy, FFT – functional family therapy, MCOs – managed care organizations; CSBs – Community Services Boards, EBP – evidence-based practice

Project BRAVO

Curb improper use of crisis services

- **Recommendation 4:** Include funding and FTEs in the 2027 Appropriation Act for DMAS to build data sharing among DMAS, DBHDS, MCOs, and CSBs, and to analyze the data to identify improper use of crisis services.
- **Explanation:** Crisis spending totaled $971 million in FY22-FY25, ~9 times the amount projected, and some of the growth reflects improper use. Crisis data is held separately by multiple entities and is not easily shared or analyzed. DMAS reports it needs at least 2 FTEs to build data sharing systems and analyze the data to detect improper use faster and more effectively. Estimated cost of 2 FTEs is 300K annually.

Project BRAVO

Curb improper use of crisis services

- **Recommendation 5:** Include language in the 2027 Appropriation Act directing the State Board of Behavioral Health and Developmental Services to promulgate regulations amending crisis service licensing regulations to strengthen protections against improper use by July 1, 2027.
- **Explanation:** Licensing standards for crisis providers in place during the launch of Project BRAVO set a low bar for entry. DBHDS reports this contributed to the influx of mobile crisis providers, some of which are improperly delivering the service. Stronger licensing regulations would help ensure high-quality crisis providers and limit improper use.

Project BRAVO recommendations would improve utilization of services, strengthen crisis oversight, and ensure effectiveness

1	**Increase utilization of underused services**	Fund training for more MST[1] and FFT[1] teams
2	**Curb improper use of crisis services**	Link crisis data across state agencies, MCOs[1], and CSBs[1] Strengthen licensing regulations for crisis services
3	**Measure effectiveness of services**	Fund EBP[1] fidelity assessment Require delivery and outcome reporting for ALL redesigned services

[1]MST – multi-systemic therapy, FFT – functional family therapy, MCOs – managed care organizations; CSBs – Community Services Boards, EBP – evidence-based practice

Project BRAVO

Measure effectiveness of services

- **Recommendation 6:** Include funding and FTEs in the 2027 Appropriation Act for DBHDS to expand capacity to conduct fidelity assessments of ACT[1] teams.
- **Explanation:** Only 30 of 85 ACT teams have been assessed since FY24, and no team has received a follow-up review. Virginia does not know whether most ACT teams deliver the model as designed, nor are all teams paid at the rate associated with the quality of care they provide. DBHDS contracts with UNC[1] to conduct assessments, and they can review about 10 teams a year. DBHDS would like to build internal capacity to conduct additional assessments, but reports needing additional funding and staff to do so. DBHDS estimates needing $565K annually for 4 FTEs.

[1]ACT – assertive community treatment, UNC – University of North Carolina

Project BRAVO and Behavioral Health Redesign

Measure effectiveness of services

- **Recommendation 9:** Include funding and FTEs in the 2027 Appropriation Act for the DBHDS Office of Clinical Quality Management to develop, track, and report on service delivery and outcome measures for all redesigned services, with reporting beginning by December 1, 2028.
- **Explanation:** Only MST[1], FFT[1], and ACT[1] are monitored for fidelity and outcomes. The other six services accounted for 87% of BRAVO spending in FY25, and the data on the quality of these services is limited and scattered across agencies. No plans have been made to measure outcomes for new services planned under Behavioral Health Redesign (BHR). DBHDS conducts fidelity and quality monitoring for ID/DD services, and reports that additional staff would allow them to expand quality monitoring to BRAVO and BHR services. DBHDS estimates needing $1M annually for 7 FTEs.

[1]MST – multi-systemic therapy, FFT – functional family therapy, ACT – assertive community treatment

BHR recommendations would strengthen the transition, build provider capacity, and monitor implementation success

1	**Prepare for the BHR transition**	Fund licensing staff Delay BHR[1] one year, in full or at least for CPST-school and Clubhouse
2	**Build provider capacity to ensure access**	Raise CPST [1] rates to 95% of median-wage rates Fully fund provider training for CPST Fund Clubhouse provider training
3	**Monitor implementation success**	Track access to BHR services, CPST hours, and spending against budget neutrality Require delivery and outcome reporting for all redesigned services Fund DMAS staff to monitor implementation

[1]BHR – Behavioral Health Redesign, CPST – community psychiatric support and treatment

Behavioral Health Redesign recommendations would strengthen the transition, build provider capacity, and monitor implementation success

1	**Prepare for the BHR transition**	Fund licensing staff Delay BHR[1] one year, in full or at least for CPST-school and Clubhouse
2	**Build provider capacity to ensure access**	Raise CPST[1] rates to 95% of median-wage rates Fully fund provider training for CPST Fund Clubhouse provider training
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[1]BHR – Behavioral Health Redesign, CPST – community psychiatric support and treatment

Behavioral Health Redesign

Prepare for transition

- **Recommendation 12:** Include funding and FTEs in the 2027 Appropriation Act for the DBHDS Office of Licensing to add licensing specialist positions.
- **Explanation:** The Office expects over 1,000 new applications during BHR rollout, tripling a typical year's workload, and reports that the 46 licensing specialists are already at capacity. The Office is strengthening licensing review processes and will also conduct two inspections a year for new BHR providers. DBHDS estimates that an additional 8 FTEs would allow them to review the additional applications without delaying current efforts. The Office estimates needing $850,000 annually for 8 FTEs.

Behavioral Health Redesign

Prepare for transition

- **Option 2:** Include language in the 2027 Appropriation Act delaying BHR implementation of all services by 1 additional year to July 1, 2028, with a 6-month phased implementation that allows legacy services to continue.

OR

- **Option 3:** Delay BHR implementation for only CPST-school and Mental Health Clubhouse, and the retirement of associated legacy services by 1 additional year to July 1, 2028, with a six-month phased implementation.
- **Explanation:** Licensing capacity, provider training, MCO authorization systems, online assessment platform, and school-based community psychiatric support and treatment (CPST) requirements are unlikely to be ready by July 1, 2027. Current law requires legacy services to end before new services begin, so individuals could lose services if replacement providers are not ready.

BHR recommendations would strengthen the transition, build provider capacity, and monitor implementation success

1	**Prepare for the BHR transition**	Fund licensing staff Delay BHR[1] one year, in full or at least for CPST-school and Clubhouse
2	**Build provider capacity to ensure access**	Raise CPST[1] rates to 95% of median-wage rates Fully fund provider training for CPST Fund Clubhouse provider training
3	**Monitor implementation success**	Track access to BHR services, CPST hours, and spending against budget neutrality Require delivery and outcome reporting for all redesigned services Fund DMAS staff to monitor implementation

[1]BHR – Behavioral Health Redesign, CPST – community psychiatric support and treatment

Behavioral Health Redesign

Build provider capacity

- **Option 1:** Include language in the 2027 Appropriation Act directing DMAS to increase CPST[1] reimbursement rates to 95 percent of the medium bound rates for all practitioner types.
- **Explanation:** To meet budget neutrality, DMAS set CPST rates at 87 percent of the rate study's recommended (medium bound) rates, placing QMHP[1] rates near the bottom of the study's range and BHT[1] rates below it. Providers report the rates will not cover their costs, and a majority of CSBs interviewed do not plan to offer CPST, which could leave some rural areas without a provider. Raising rates to 95 percent would cost about $30 million, or less if limited to QMHPs and BHTs, but could undermine budget neutrality.

[1]CPST – community psychiatric support and treatment, QMHP – qualified mental health professional, BHT – behavioral health technician

Behavioral Health Redesign

Build provider capacity

- **Recommendation 13:** Include one-time funding in the 2027 Appropriation Act for DBHDS to establish a grant program to pay for provider training costs for BHR services, including MAP[1], transdiagnostic CBT[1], and CANS[1] Lifetime.
- **Explanation:** BHR adds training requirements that few providers have completed, and some training is not yet available. The state is allowing a grace period, which risks services not being delivered as intended. DBHDS estimates $300K would train 12 state trainers and about 7,000 providers on CANS Lifetime but has no funding source. Additional funding would be needed for the other required trainings, such as MAP and transdiagnostic CBT.

[1]MAP – Managing and Adapting Practice, CBT – Cognitive Behavioral Therapy, CANS – Comprehensive Assessment of Needs and Strengths

Behavioral Health Redesign

Build provider capacity

- **Recommendation 11:** Include funding in the 2027 Appropriation Act for DBHDS to establish a grant program supporting training of Mental Health Clubhouse sites.
- **Explanation:** Training costs are a barrier to providers offering Clubhouse services. Clubhouse training costs $7,000 to $11,000 per site, and training bases are out of state with limited capacity. DMAS has no funding to help providers cover the cost of this training. Without additional funding for training, few Clubhouse programs will be trained by the launch of BHR and some providers may not offer the service, leaving Medicaid members who need the service unable to find a provider. DBHDS estimates it will cost $440,000 to train the number of providers needed.

BHR recommendations would strengthen the transition, build provider capacity, and monitor implementation success

1	**Prepare for the BHR transition**	Fund licensing staff Delay BHR[1] one year, in full or at least for CPST-school and Clubhouse
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[1]BHR – Behavioral Health Redesign, CPST – community psychiatric support and treatment

Behavioral Health Redesign

Monitor implementation success

- **Recommendation 10:** Include language in the 2027 Appropriation Act directing DMAS to assess whether CPST[1] service hours are sufficient and report findings and recommended changes to BHC annually beginning December 1, 2028.
- **Explanation:** CPST allows 8.5 to 28 hours per month, far below the legacy services it replaces. It is not known whether these hours will be sufficient to meet need as hours were set to achieve budget neutrality, not based on research. If hours are too low, individuals may shift to crisis services, emergency departments, and inpatient care. The assessment would track hours authorized, share of recipients reaching limits, and emergency department, inpatient, and crisis use.

[1]CPST – community psychiatric support and treatment

Behavioral Health Redesign

Monitor implementation success

- **Recommendation 15:** Include language in the 2027 Appropriation Act directing DMAS to identify measures of BHR access and spending compared with the budget neutral baseline, propose them to the BHC by November 1, 2027, and report performance annually beginning July 1, 2028.
- **Explanation:** No entity is responsible for monitoring BHR implementation, and DMAS has no formal plans to assess it. BHR affects over 31,000 individuals and about $315 million in annual spending. Without monitoring, Virginia risks repeating Project BRAVO's delays in identifying cost overruns and access gaps.

Behavioral Health Redesign

Monitor implementation success

- **Recommendation 16:** Include funding and FTEs in the 2027 Appropriation Act for DMAS to add an analyst position to the Behavioral Health Division.
- **Explanation:** DMAS employs no behavioral health analysts, and the staff member most familiar with behavioral health data also supports every Medicaid waiver, nursing facilities, and developmental disability services. The Behavioral Health Division has received no additional resources to plan BHR or assess it after launch. The analyst would develop, track, and report the access and spending measures in Recommendation 15. DMAS estimates needing $150,000 annually for 1 FTE.

Jail study recommendations would ensure implementation of minimum behavioral health standards and direct needed resources to jails

1 Ensure prompt adoption of minimum standards and set clear expectations	Set deadlines for BLRJ[1] to promulgate regulations Clarify statutory expectations for provision of behavioral health services Adopt standards for mental health monitoring of inmates on suicide watch Develop and implement guidance documents that detail expectations for jails
2 Provide resources for jails to meet standards and for BLRJ to enforce them	Add staff at BLRJ for policy planning and enforcement Provide state funding for 75 behavioral health case managers, at least 2 per jail Expand state-funded discharge planning program to all jails Pursue Medicaid re-entry waiver Explore state pharmacy contracts and federal program for lower-cost medications Create guidance for CSBs on pre-screening inmates in crisis

[1]BLRJ – Board of Local and Regional Jails

Jail study recommendations would ensure implementation of minimum behavioral health standards and direct needed resources to jails

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[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **Recommendation 7:** Direct Board of Local and Regional Jails (BLRJ) to adopt regulations by July 1, 2027 on behavioral health screening, assessment referrals, discharge planning, records sharing, and CSB billing, and on the provision of services by the first day of the 2028 General Assembly session.
- **Explanation:** BLRJ has made limited progress turning the statutory behavioral health requirements into regulations. Draft screening and assessment standards have not been voted on by the full Board, discharge planning language stalled in committee over feasibility concerns, and no drafts exist yet for provision of behavioral health services, records sharing, or CSB billing.

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **Recommendation 8:** Amend § 53.1-68(C) to add specificity to the standard for "provision of behavioral health services" including: access to care; communication of inmate needs; continuity and coordination of services; restrictive housing; primary mental health services; and management of intoxication, withdrawal, and overdose.
- **Explanation:** BLRJ[1] must set minimum standards for the "provision of behavioral health services," but the statutory language is vague compared to the requirements for screening, assessment, and discharge planning. Adding specificity in statute, drawing on 6 standards the Board adopted in 2020 that current regulatory revisions do not address, would help ensure the legislature's intent is carried out in regulations.

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **Option 2:** Direct BLRJ[1] to promulgate regulations, by the first day of the 2028 session, requiring that inmates on suicide watch or in segregation for mental health reasons be evaluated by a medical or mental health provider within 12 hours of placement and by a mental health provider at least every 24 hours thereafter.
- **Explanation:** Suicide watch is meant to keep inmates safe, but its severe conditions—isolation, no clothes, no personal items, constant lighting—can worsen the mental health of a person in crisis. Virginia has no regulations requiring mental health monitoring for inmates on suicide watch or in administrative segregation.

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **Recommendation 9:** Direct the Secretary of Public Safety and Homeland Security, with the Secretary of Health and Human Resources, to convene a stakeholder task force to develop proposed guidance and compliance indicators for behavioral health regulations that account for differences among jails and identify needed funding, and to submit them to BLRJ[1] and the BHC by November 15, 2027.
- **Explanation:** Without regulatory guidance, behavioral health care will continue to vary among jails, and small jails with limited staff, funding, and space will have the hardest time complying. A task force building on the 2020 compliance indicators and stakeholder workgroup could draft guidance that balances rigor and feasibility, including tiered indicators based on jail size or local fiscal conditions.

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **Recommendation 10:** Direct BLRJ[1] to adopt guidance documents and compliance indicators for § 53.1-68(C) regulations and publish them in the Virginia Register of Regulations by June 30, 2028.
- **Explanation:** This establishes a timeline for BLRJ to adopt guidance documents and compliance indicators to ensure that they are taken up within a reasonable timeframe.

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Ensure prompt adoption of standards and set clear expectations

- **All recommendations aimed at ensuring the prompt adoption of standards and setting clear expectations could be implemented in 1 bill with enactment clauses**
  - Bill to amend § 53.1-68(C) to add specificity to the standard for "provision of behavioral health services" (Recommendation 8), including the provision of monitoring for inmates on suicide watch (Option 2)
  - Enactment clauses that
    1) Direct BLRJ[1] to adopt regulations on screening, referrals, discharge planning, records sharing, and CSB billing by July 1, 2027 (Recommendation 7)
    2) Direct BLRJ to adopt regulations on provision of services (Recommendation 7) by the first day of 2028 session
    3) Direct the Secretary of Public Safety & Homeland Security to convene a task force to develop guidance documents and compliance indicators for behavioral health regulations by November 15, 2027 (Recommendation 9)
    4) Direct BLRJ to adopt guidance documents and compliance indicators by June 30, 2028 (Recommendation 10)

[1]BLRJ – Board of Local and Regional Jails

Jail study recommendations would ensure implementation of minimum behavioral health standards and direct needed resources to jails

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2	**Provide resources for jails to meet standards and for BLRJ to enforce them**	Add staff at BLRJ for policy planning and enforcement Provide state funding for 75 behavioral health case managers, at least 2 per jail Expand state-funded discharge planning program to all jails Pursue Medicaid re-entry waiver Explore state pharmacy contracts and federal program for lower-cost medications Create guidance for CSBs on pre-screening inmates in crisis

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Recommendation 11:** Include funding and FTEs in the 2027 Appropriation Act for BLRJ[1] to hire one policy analyst and two compliance analysts.
- **Explanation:** Adopting new behavioral health standards and guidance would add substantially to the workload of BLRJ staff, who will be responsible for helping to promulgate regulations and inspecting jails against new standards. A 2021 DCJS report found the Board lacked sufficient capacity to take on additional responsibilities related to behavioral health standards. BLRJ confirms being understaffed, with 8 FTEs that handle all regulations, audits, inspections, death reviews, and required reports. Estimated funding for 3 FTEs is $300,000 annually.

[1]BLRJ – Board of Local and Regional Jails

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Recommendation 3:** Include funding in the 2027 Appropriation Act for the Compensation Board to allocate all behavioral health case manager positions needed to meet DCJS' recommended staffing standard of one per 160 inmates, with at least two per jail, and to specify that the funds may be used only for behavioral health treatment, services, planning, and coordination.
- **Explanation:** Behavioral health case managers (BHCMs) appear effective where jails have hired them, but current funding covers only 125 positions, roughly 75 short of the approximately 200 needed to meet DCJS's 1:160 staffing standard with at least two per jail. Two BHCMs per jail is the minimum needed to ensure coverage 7 days a week. Funding for 75 additional BHCMs would cost ~$4.1 million annually.

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Option 1:** Include funding in the 2027 Appropriation Act for DBHDS to expand forensic discharge planning programs (i) to be implemented in jails that do not currently participate; and (ii) to serve additional inmates in jails that already participate in the program.
- **Explanation:** Once statutorily required discharge planning regulations are finalized, all jails will be required to provide discharge planning for inmates with SMI[1]. DBHDS operates a forensic discharge planning program though CSBs, but that program currently serves only 29 out of 66 jail sites. Extending the program to all sites would cost ~$5.1M annually to support 37 additional forensic discharge planners and 3 FTEs at DBHDS.

[1]SMI – serious mental illness

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Recommendation 5:** Include language and funding for FY 2026 in the 2027 Appropriation Act directing DMAS to apply to CMS for a Section 1115 reentry waiver for Medicaid payment of health care services for inmates, including behavioral health services. DMAS should give an interim progress report to the BHC by December 1, 2027 and should submit the application to CMS by July 1, 2028.
- **Explanation:** Medicaid generally cannot pay for health care for people in jail, which can leave gaps in care at reentry, when overdose risk is highest. An 1115 reentry waiver would let Virginia use Medicaid to supplement local spending by covering behavioral health services for up to 90 days before release. Estimated funding needed includes $500k ($250k in each year) to support an application contractor and $117k for 1 FTE at DMAS.

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Recommendation 2:** Include language in the 2027 Appropriation Act directing the Secretary of Health and Human Resources to convene a workgroup, including the Compensation Board and relevant agencies, to study lowering jails' costs for psychotropic, opioid use disorder, and long-acting injectable antipsychotic medications and report to the BHC by November 1, 2027.
- **Explanation:** Medication is an essential part of jail behavioral health treatment strategies, but the high costs can strain jails and put effective medications out of reach. Several options exist to reduce the cost of behavioral health medications in jails, including a state pharmacy contract and 340B arrangements, and determining which best fits Virginia would require further study.

Behavioral health services in jails

Provide resources for jails to meet standards and for BLRJ enforcement

- **Recommendation 6:** Include language in the 2027 Appropriation Act directing DBHDS to form a workgroup that includes CSB staff and jail stakeholders to develop protocols to guide the pre-admission screening process for inmates of local and regional jails. DBHDS should issue a final guidance document to CSBs and report on the guidance to the BHC by November 1, 2027.
- **Explanation:** Jails can seek a TDO[1] for inmates in acute crisis, but only a CSB pre-screener can do the evaluation to determine if an inmate meets the criteria. Jail staff report that CSBs sometimes decline to conduct pre-screens and apply eligibility criteria inconsistently, in part because a jail can keep an inmate alive through segregation or suicide watch, which is not the same as treating them.

[1]TDO – temporary detention order

In this presentation

2026 studies

Recommendations from past studies

Unsuccessful recommendations from 2025 studies could be re-introduced in 2027 legislative session

- Implementation and effectiveness of Marcus Alert
- Aligning crisis services and the civil commitment process
- STEP-VA implementation and performance monitoring

Follow-up to 2025 BHC recommendations
Implementation and effectiveness of Marcus Alert

- **Option 4:** Include funding and 1 FTE in the Appropriation Act to support hiring one co-response coordinator at DCJS.
- **Explanation:** Virginia's co-response teams vary widely in practice, and state agencies have limited oversight or data on what makes them effective. With many new teams likely to form as more localities adopt Marcus Alert, a dedicated DCJS coordinator could encourage new teams and promote best practices, helping them divert people in crisis from the criminal justice system. Estimated funding needed is $125K annually.
- **History:** Introduced in 2026 but not included in final budget

Follow-up to 2025 BHC recommendations
Implementation and effectiveness of Marcus Alert

- **Recommendation 6:** Include funding and 1 FTE in the Appropriation Act for DBHDS to hire an analyst responsible for evaluating the Marcus Alert system's performance.
- **Explanation:** The Marcus Alert Evaluation Task Force requires 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. Estimated funding needed is $150K annually.
- **History:** Introduced in 2026 but not included in final budget

Follow-up to 2025 BHC recommendations
Aligning crisis services and the civil commitment process

- **Option 2:** Include language in the Appropriation Act directing the HRR 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).
- **Explanation:** Regional mobile crisis teams are rarely dispatched for third-party calls, which disproportionately involve individuals meeting Level 3 criteria (at high risk for ECO[1] but no imminent public safety risk). Without in-person care, these individuals may deteriorate. Extensive state and federal regulations make it unclear whether third-party dispatch is permitted, but some states appear to dispatch teams based on third-party referrals.
- **History:** Introduced in 2026 but not included in final budget

[1]ECO – emergency custody order

Follow-up to 2025 BHC recommendations
STEP-VA implementation and performance monitoring

- **Recommendation 1:** Include language in the Appropriation Act to appropriate STEP-VA[1] funding as one amount rather than by individual STEP.
- **Explanation:** 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 of CSBs to respond to changing community needs and to address capacity gaps.
- **History:** Introduced in 2026 but not included in final budget

[1]STEP-VA – System Transformation Excellence and Performance of Virginia

Next steps

- Staff will reach out to members after the November meeting to identify patrons
  - Members can volunteer if interested in specific recommendations
  - Other recommendations may be assigned based on members' committee assignments and relevance to topic
- Staff will draft budget amendments and work with DLS on bill drafting
  - Bills or placeholders will be prefiled by deadline
  - Patrons will review budget and bill language
- Draft bills and budget amendments will be available to Commission members in December