DBHDS
Virginia Department of Behavioral Health and Developmental Services

AGENDA PACKET

AS ADOPTED

State Board of Behavioral Health and Developmental Services

Schedule of Events

TUESDAY, APRIL 21, 2026

Fairfax-Falls Church Community Services Board Sharon Bulova Center for Community Health 8221 Willow Oaks Corporate Drive, Fairfax, VA 22031	
4:00 p.m.	**BOARD MEMBER PROGRAM TOUR** • Use **South Lobby Entrance**, far right door, next to parking garage behind building • Review entry procedures for screening and prohibited items
6:00 p.m.	**DINNER MEETING** Alta Strada – Mosaic 2911 District Avenue, Fairfax, VA 22031 • **Attendees:** Board Members, DBHDS Staff, CSB Staff • ***No business will be conducted***

WEDNESDAY, APRIL 22, 2026

Northern Virginia Mental Health Institute (NVMHI) 3302 Gallows Road, Falls Church, VA 22042	
Meetings are in person with a physical quorum present; however, electronic meeting access is available.	
8:30 a.m.	**CONCURRENT COMMITTEE MEETINGS**
9:30 a.m.	**REGULAR QUARTERLY BOARD MEETING**

AGENDA PACKET

AS ADOPTED

State Board of Behavioral Health and Developmental Services

Wednesday, April 22, 2026

Northern Virginia Mental Health Institute (NVMHI)
3302 Gallows Road, Falls Church, VA 22042

Meetings are in person with a physical quorum present; however, electronic meeting access is available.

8:30 a.m. — **POLICY AND EVALUATION COMMITTEE MEETING**
Director's Conference Room

Membership: McDonald, Graser, Lamb, Schroder, Coster

Electronic Meeting Access:	
Microsoft Teams	Click here to join Committee Meeting
Meeting ID:	221 593 242 766 0
Passcode:	3Hr2T943
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	357 437 291#

Agenda, pages **21-33**

8:30 a.m. — **PLANNING AND BUDGET COMMITTEE MEETING**
Meeting Room A128

Membership: Andis, Chung, Vadella, Marrs

Electronic Meeting Access:	
Microsoft Teams	Click here to join Committee Meeting
Meeting ID:	250 725 626 286 24
Passcode:	oq2vT3oe
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	795 581 056#

Agenda, pages **34-36**

9:30 a.m. — **REGULAR QUARTERLY BOARD MEETING**
Meeting Room A128

Electronic Meeting Access:	
Microsoft Teams	Click here to join Full Board Meeting
Meeting ID:	250 725 626 286 24
Passcode:	oq2vT3oe
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	795 581 056#

Agenda, pages **3-4**

State Board of Behavioral Health and Developmental Services

WEDNESDAY, APRIL 22, 2026

Regular Quarterly Board Meeting

9:30 a.m.

Northern Virginia Mental Health Institute (NVMHI)
3302 Gallows Road, Falls Church, VA 22042

ELECTRONIC MEETING ACCESS	
Microsoft Teams	Click here to join
Meeting ID:	250 725 626 286 24
Passcode:	oq2vT3oe
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	795 581 056#

Meeting is in person with a physical quorum present; however, electronic meeting access is available.

1.	**CALL TO ORDER**		
	A. Determination of Quorum **B.** Welcome and Introductions **C.** Adoption of Agenda **D.** Approval of Draft Minutes	Action Item	Pages **5-20**
2.	**PUBLIC COMMENT**		
	Public comment on agenda items will be accepted in person or virtually using the electronic meeting access option. Comment will not be accepted on regulatory actions or rulemaking petitions for which the public comment period has closed. Each commenter, whether in-person or virtual, will be limited to three minutes. **Pre-registration is requested but not required.** Persons wishing to comment are asked to email mary.broz-vaughan@dbhds.virginia.gov by 5:00 p.m., on Tuesday, April 21, 2026.		
3.	**STANDING COMMITTEE REPORTS**		
4.	**UNFINISHED BUSINESS**		
5.	**REGULATORY BUSINESS**		
	A. *REVISED* Emergency/NOIRA Action to Align Licensing Regulations with Redesigned Medicaid Service: Coordinated Specialty Care (CSC)	Action Item	Pages **42-65**
	B. Regulatory Activity Status Report	Information	Pages **66-67**

6.	**FACILITY TOUR**
	Board Members and DBHDS staff only. *Facility tours are not open to the public due to patient confidentiality and safety.*
7.	**FACILITY OVERVIEW**
8.	**COMMISSIONER'S REPORT**
9.	**LUNCH**
	Break and collect lunch
10.	**POST-SESSION LEGISLATIVE AND BUDGET UPDATE**
11.	**DBHDS PRESENTATION: CERTIFIED RECOVERY RESIDENCES**
12.	**DBHDS PRESENTATION: COMMUNICATIONS AND OUTREACH UPDATE**
13.	**VACSB UPDATE**
14.	**NEW BUSINESS**
15.	**ANNOUNCEMENTS**
16.	**ADJOURNMENT**

NEXT MEETING: WEDNESDAY, JULY 15, 2026
Piedmont Geriatric Hospital
5001 E. Patrick Henry Hwy., Burkeville, VA 23922

The agenda and packet as adopted by the Board was made available to the public at the meeting in accordance with the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

DBHDS
Virginia Department of Behavioral Health and Developmental Services

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

REGULAR QUARTERLY BOARD MEETING

Wednesday, December 10, 2025

DBHDS Central Office, 13th Floor South Conference Room
Jefferson Building, 1220 Bank Street, Richmond, VA 23219

The meeting was held in person with a physical quorum present and with electronic or phone connection available.

MEMBERS PRESENT	R. Blake Andis Sandy Chung, MD Caroline Coster, MD Rebecca Graser Cindy Lamb Debbie Marrs Jane McDonald Nina Schroder	MEMBERS ABSENT	Tony Vadella
DBHDS STAFF present for all or part of the meeting	Mary Broz-Vaughan, Regulatory Affairs Director/State Board Liaison Kassi Cibulka, Chief Human Resource Officer Lauren Cunningham, Communications Director Taneika Goldman, State Human Rights Director Madelyn Lent, Public Policy Manager Josie Mace, Legislative Affairs Director Nathan Miles, Chief Financial Officer Meghan McGuire, Deputy Commissioner, Policy and Public Affairs Susan Puglisi, Regulatory Research Specialist Nelson Smith, Commissioner		
INVITED GUESTS present for all or part of the meeting	Will Childers, State Human Rights Committee Chair Jennifer Faison, VACSB Executive Director Matthew Hawkins, Virginia COI and Ethics Council Attorney Stewart Petoe, Virginia COI and Ethics Council Executive Director		
VIRTUAL ATTENDEES	DBHDS: Jae Benz, Director of Licensing; Eric Billings, Director of Grants Management; Braden Curtis, Chief Deputy Commissioner; Dev Nair, Assistant Commissioner for Provider Management EXTERNAL: LeVar Bowers; Martha Bryant; Scott Castro, MSV; Alisa Foley, DSS; Catherine Ford, MSV; Lauren Gerken, The Arc of Virginia; Cara Kaufman, DARS; Heather Petrus; Teresa Smith, OSIG.		

CALL TO ORDER	Acting as chair pro tem at the request of the Board Chair, who was unable to attend in person, Vice Chair Jane McDonald called the meeting to order at 9:30 a.m.
Determination of Quorum	Ms. Broz-Vaughan called the roll and reported that a quorum was present. For purposes of determining whether a quorum was physically assembled, Ms. Marrs participated electronically as a caregiver for a person with a disability in accordance with § 2.2-3708.3 B 2 of the Code of Virginia.
Remote Participation	Noting his principal residence is more than 60 miles from the meeting location, Sheriff Andis participated electronically from his office in Washington County. Dr. Chung participated electronically from her principal residence in Sterling, which is more than 60 miles from the meeting location. Ms. Marrs participated electronically from her home in Bedford, due to caregiving responsibilities for a person with a disability at the time the meeting was held that prevented her physical attendance.
Introductions	Ms. McDonald welcomed Caroline Coster and Debbie Marrs to the board and asked for introductions from other members, DBHDS staff, and meeting attendees.
Adoption of Agenda	A motion was made by Ms. Lamb and seconded by Ms. Graser to adopt the agenda. The motion carried unanimously.
Approval of Minutes	Ms. McDonald called for any additions or corrections to the draft minutes from the meetings on September 23rd and 24th. Hearing none, Ms. Lamb moved to approve the draft minutes en bloc. Ms. Schroder seconded the motion, which carried unanimously.
9:38 a.m.	Arrival of Dr. Chung.
PUBLIC COMMENT	Ms. McDonald opened the floor for public comment. No in-person commenters were present. Martha Bryant, a mother and guardian from Amherst County, offered comment virtually. Ms. McDonald closed public comment.
REORDERING OF AGENDA	Ms. McDonald requested unanimous consent to take business out of order to accommodate Commissioner Smith's schedule. Without objection, board members agreed to reorder the agenda.

STANDING COMMITTEE REPORT	Ms. Lent summarized the morning's Policy and Evaluation Committee meeting, reporting that members revised the policy plan schedule to delay future reviews by one meeting cycle and to realign the review sequence for closely related policies under Chapter 1: System Mission and Direction. The committee reviewed proposed revisions to Policy 3000 (CO) 74-10 – Appointments of Department Employees to Community Services Boards, as well as comments received from field review. Committee members discussed data requested at the September meeting and an initial draft of agency-recommended revisions concerning Policy 6005 (FIN) 94-2 – Retention of Unspent State Funds by Community Services Boards. The draft will go out for field review for the committee to consider at its next meeting. The committee voted to recommend Policy 2011 (ADM) 88-3 – Naming of Buildings, Rooms, and Other Areas at State Facilities to the full board with revisions, which Ms. Lent indicated would be included in the next quarterly meeting agenda packet.
UNFINISHED BUSINESS	Ms. Lent reminded the board that the Policy and Evaluation Committee voted to recommend technical changes to Policy 4018 (CSB) 86-9 – Community Services Board Performance Contracts. Ms. McDonald directed members to the recommended revisions in the agenda packet. On a motion by Ms. Lamb, properly seconded by Ms. Graser, the board unanimously approved the revisions to Policy 4018 as presented.
REGULATORY BUSINESS	Ms. McDonald asked Ms. Puglisi to review the agenda items authorizing two Emergency/Notice of Intended Regulatory Action (NOIRA) actions and the Proposed stage for Regulatory Restructuring.
Action Item A	Emergency/NOIRA Action to Align Licensing Regulations with Redesigned Medicaid Service: Coordinated Specialty Care (CSC) Ms. Puglisi explained that the 2025 Session of the General Assembly directed the board to adopt emergency regulations by February 6, 2026, to align the licensing regulations with DMAS behavioral health redesigned services. She summarized the proposed amendments and impact of the CSC service, which provides team-based, collaborative, recovery-oriented treatment for individuals experiencing a first episode of psychosis. The action is intended to improve access to a continuum of high-quality behavioral health services for Virginians; ensure CSC providers adhere to a base level of model fidelity; and reduce administrative burden by aligning DBHDS licensing regulations with Medicaid service expectations.

	Dr. Coster suggested a clarifying amendment to the definition of "health literacy support." MOTION: Sheriff Andis moved to adopt emergency regulations amending 12VAC35-105 to align with Medicaid behavioral health services redesign for Coordinated Specialty Care, as amended, and to issue a NOIRA for permanent replacement regulations. Ms. Schroder seconded, and the motion carried unanimously.
Action Item B	Emergency/NOIRA Action to Align Licensing Regulations with Redesigned Medicaid Service: Recovery and Empowerment Center (REC) Ms. Puglisi reviewed the legislative mandate requiring consistency between the new Medicaid Mental Health Clubhouse Service and the licensing regulations. She summarized the proposed amendments and their impact, noting the goal of Recovery and Empowerment Center (REC) is to support the recovery of individuals living with serious mental illness through community-based environments that foster social connection, meaningful engagement, and skill development. The action is intended to improve access to a continuum of high-quality behavioral health services for Virginians; ensure REC providers adhere to a base level of model fidelity; and reduce administrative burden by aligning licensing regulations with Medicaid service expectations. MOTION: Ms. Lamb moved to adopt emergency regulations amending 12VAC35-105 to align with Medicaid behavioral health services redesign for Recovery and Empowerment Center, as presented, and to issue a NOIRA for permanent replacement regulations. Ms. Graser seconded, and the motion carried unanimously.
Action Item C	Proposed Regulatory Restructuring Actions Ms. Puglisi reminded members of the NOIRA authorized in April to repeal the existing Children's Residential (12VAC35-46) and Licensing Regulations (12VAC35-105) and replace them with one overarching General Chapter applicable to all providers and five service-specific chapters: Residential, Center-Based, NonCenter-Based, Crisis, and Case Management. The NOIRA stage closed on September 24, 2025, with 37 comments from 16 unique commenters. Ms. Puglisi explained that, although initially drafted as a comprehensive "overhaul" in 2019, the project is now more narrowly focused on improved navigation and transparency. Proposed changes incorporate significant stakeholder feedback and reflect technical assistance from a panel of subject matter experts.

	Additionally, Regulatory Restructuring is not at odds with Medicaid Behavioral Health Redesign efforts. Regulatory actions are not permitted to incorporate changes outside of their scope; each must move forward independently. Ms. Puglisi assured members that once the DMAS redesign actions take effect, all new services will be incorporated into the restructured licensing chapters. MOTION: Ms. Graser moved to adopt the proposed actions to restructure the licensing regulations, as presented. Ms. Lamb seconded, and the motion carried unanimously.
Action Item D	Petition for Rulemaking: Amend 18VAC35-105-1840 to authorize crisis stabilization units to base nursing coverage on ISP-driven, two-tier nursing model instead of 24/7 nursing services staffing. Ms. Broz-Vaughan reviewed the rulemaking petition process. Ms. McDonald directed members' attention to the DBHDS staff analysis of the petitioner's request in the agenda packet. Granting the petition would reduce consistency for providers because DBHDS licensing regulations are not more stringent than DMAS policy regarding 24/7 in-person, onsite nursing coverage for crisis stabilization units. The staff recommends taking no action on the petition because 12VAC35-105-1840 is already aligned with Medicaid standards. MOTION: Ms. Schroder moved to take no action on the petition based on the rationale recommended by staff. Ms. Lamb seconded, and the motion carried unanimously.
COMMISSIONER'S REPORT	Commissioner Nelson Smith briefed members on the progress of *Right Help, Right Now*, as well as how DBHDS transformed as an agency in support of the initiative. • Presentation available from board office upon request.
Recess	Ms. McDonald recessed the meeting for a short break.
The Board recessed at 11:00 a.m. to reconvene at 11:10 a.m.	
The Board reconvened at 11:10 a.m.	
OFFICE OF HUMAN RIGHTS UPDATE	Mr. Childers expressed his appreciation to the board on behalf of the State Human Rights Committee. Ms. Goldman reviewed the activities and achievements of the Office of Human Rights for 2024-2025. • Presentation available from board office upon request.
Lunch Recess	Ms. McDonald recessed the meeting for lunch.

The Board recessed at 11:35 a.m. to reconvene at 11:55 a.m.	
The Board reconvened at 11:55 a.m.	
PRE-SESSION LEGISLATIVE AND BUDGET UPDATE	Mr. Miles summarized significant DBHDS budget requests submitted for the governor's proposed budget to be released on December 17, 2025. Ms. Mace noted that the General Assembly convenes on January 14, 2026, for its "long" 60-day session and reminded board members of their role and responsibilities.
NEW BUSINESS	Ms. McDonald directed members to revisions to the board's bylaws and electronic meetings policy necessary to conform to the Virginia Freedom of Information Act. On a motion by Ms. Graser, properly seconded by Ms. Lamb, the board unanimously adopted the revisions as presented.
Chair's Annual Report	Ms. McDonald reviewed the statutory requirement for the Board Chair to submit an annual report to the governor and the General Assembly summarizing the board's work for the year. Members received a handout with a draft of the legislative report. Ms. McDonald noted that as a matter of practice the chair customarily provides final approval and asks for the board's endorsement. On a motion by Ms. Lamb, properly seconded by Ms. Graser, the board unanimously endorsed the annual summary as approved by the chair.
Committee Assignments	Ms. Broz-Vaughan announced committee appointments made by the Board Chair as follows: Planning and Budget Committee Blake Andis Sandy Chung, MD Tony Vadella Debbie Marrs Policy and Evaluation Committee Jane McDonald Becky Graser Cindy Lamb Nina Coster Caroline Coster, MD Members received a handout with the new committee assignments.

BIENNIAL CONFLICT OF INTEREST TRAINING	Mr. Hawkins trained members on formal and informal guidance and "safe harbor" provisions, prohibited conduct and personal interests, and annual filing requirements under the State and Local Government Conflict of Interests Act.
VACSB UPDATE	Ms. Faison briefed the board on Virginia Association of Community Services Boards (VACSB) budget and policy priorities for the 2026 General Assembly Session.
ADJOURNMENT	Ms. McDonald adjourned the meeting at 1:10 p.m.
The State Board adjourned at 1:10 p.m.	

NEXT MEETING SCHEDULED FOR WEDNESDAY, APRIL 22, 2025

Northern Virginia Mental Health Institute (NVMHI)

3302 Gallows Road, Falls Church

NEW BUSINESS: Committee Assignments

DBHDS
Virginia Department of Behavioral Health and Developmental Services

State Board of Behavioral Health and Developmental Services

STANDING COMMITTEES

Planning and Budget

The Planning and Budget Committee shall consist of the Board Chair and at least two other Board members appointed by the Chair. The Board Chair shall chair the Planning and Budget Committee. (Bylaws Article VII. Section 1.2)

Blake Andis, Committee Chair
Sandy Chung, MD
Tony Vadella
Debbie Marrs

Policy Development and Evaluation

The Policy Development and Evaluation Committee shall consist of the Vice Chair and at least two other Board members appointed by the Board Chair. The Board Vice Chair shall chair the Policy Development and Evaluation Committee. (Bylaws Article VII. Section 1.1)

Jane McDonald, Committee Chair
Becky Graser
Cindy Lamb
Nina Schroder
Caroline Coster, MD

BIENNIAL CONFLICT OF INTEREST TRAINING HANDOUT

VIRGINIA
CONFLICT OF INTEREST AND
ETHICS ADVISORY COUNCIL

Virginia Department of Behavioral Health and Developmental Services
Board Training
December 10, 2025

I. Council Membership
Council membership as of November 2025:

Speaker of the House Appointees
Delegate M. Keith Hodges
Delegate Vivian E. Watts
The Honorable Westbrook J. Parker

Senate Committee on Rules Appointees
Senator Adam P. Ebbin
Senator Richard H. Stuart
The Honorable Malfourd W. Trumbo (Chair)

Gubernatorial Appointees
John C. Blair
Denise B. Burch
Adam Kinsman

II. Council Duties
The Council shall perform the following duties:

1. Furnish formal and informal guidance to all persons required to comply with the Acts
2. Conduct training seminars and educational programs and publish educational materials for all persons required to comply with the Acts
3. Serve as liaison between state agencies, boards, commissions, and local government entities for administering the filings of all disclosure forms
4. Redact personal information from any form prior to making the form available to the public
5. Establish and maintain a searchable database of disclosure forms filed with the Council
6. Notify the Secretary of the Commonwealth and the Attorney General concerning late or failure-to-file penalties
7. Receive and review requests for approval of travel submitted by individuals required to file a Statement of Economic Interests

III. Prohibited Conduct and Personal Interests

A. Prohibited Conduct
No state or local government officer or employee shall:

1. Solicit or accept money or other thing of value for services performed within the scope of your official duties except for compensation paid by your agency
2. Offer or accept any money or other thing of value for obtaining employment, appointment, or promotion of any person with any governmental or advisory agency

3. Offer or accept any money or other thing of value for the use of your public position to obtain a contract for any person or business with any governmental or advisory agency
4. Use confidential information that you have acquired by reason of your public position and that is not available to the public for your or another party's economic benefit
5. Accept any money, loan, gift, favor, service, or business or professional opportunity that reasonably tends to influence you in the performance of your official duties; this does not include political contributions actually used for a political campaign or constituent services and reported as required by campaign finance laws
6. Accept any business or professional opportunity when you know that there is a reasonable likelihood that the opportunity is being given to influence you in the performance of your official duties
7. Accept any honoraria for any appearance, speech, or article in which you provide expertise or opinions related to the performance of your official duties (this only applies to the Governor, Lt. Governor, Attorney General, Governor's Secretaries, and heads of departments of state government)
8. Accept a gift from a person who has interests that may be substantially affected by the performance of your duties under circumstances where the timing and nature of the gift would cause a reasonable person to question your impartiality in the matter affecting the donor
9. Accept gifts from sources on a basis so frequent as to raise an appearance of the use of your public office for private gain
10. Use your public position to retaliate or threaten to retaliate against any person for expressing views on matters of public concern or for exercising any right that is otherwise protected by law, provided, however, that this does not restrict the authority of any public employer to govern conduct of its employees, and to take disciplinary action, in accordance with applicable law, and provided further that this does not limit the authority of a constitutional officer to discipline or discharge an employee with or without cause

B. "Personal interest" is a financial benefit or liability accruing to an officer or employee or to a member of his immediate family.

Personal interests exist due to:

1. Ownership in a business if the ownership interest exceeds three percent of the total equity of the business;
2. Annual income that exceeds, or may reasonably be anticipated to exceed, $5,000 from ownership in real or personal property or a business;
3. Salary, other compensation, fringe benefits, or benefits from the use of property, or any combination thereof, paid or provided by a business or governmental agency that exceeds, or may reasonably be anticipated to exceed, $5,000 annually;

4. Ownership of real or personal property if the interest exceeds $5,000 in value and excluding ownership in a business, income, or salary, other compensation, fringe benefits or benefits from the use of property;
5. Personal liability incurred or assumed on behalf of a business if the liability exceeds three percent of the asset value of the business; or
6. An option for ownership of a business or real or personal property if the ownership interest will consist of subdivision (1) or (4) above.

C. Personal Interest in a Contract

1. You may not have a personal interest in a contract with your agency other than your own contract of employment.
2. You are also prohibited from having a personal interest in certain contracts with other state agencies.
   For contracts with other state agencies, an exception is made for:

   i. contracts awarded using competitive sealed bidding or negotiation following Procurement Act procedures

   ii. contracts awarded after a written finding by the administrative head of the agency that competitive sealed bidding or negotiation is contrary to the best interest of the public.

There are many exceptions to this prohibition. It is recommended that you contact the Council regarding the application of an exception.

D. Personal Interest in a Transaction

A personal interest in a transaction means a personal interest in any matter considered by your agency, when official action is taken or contemplated.

Such a personal interest exists when you or a member of your immediate family has a personal interest in:

1. property or a business, or
2. represents or provides services to any individual or business

and the property, business, or represented or served individual or business

1. is the subject of the transaction or
2. may realize a reasonably foreseeable direct or indirect benefit or detriment as a result of the action on the transaction.

You must publicly disqualify yourself if the transaction applies solely to the entity in which you have a personal interest, or if you have a personal interest in a transaction and do not qualify for participation.

It is recommended that you contact the Council if you have a question about a possible personal interest in a transaction.

IV. Filing Requirements

A. Who must file?
   1. Individuals named in § 2.2-3114
   2. Individuals named in Executive Order 18 (2022)

B. With what entity do I file?
You are required to file electronically with the Virginia Conflict of Interest and Ethics Advisory Council, using the online filing system provided by the Council.

C. When do I file?
Financial Disclosure Statements are filed annually with the Council, every February 1.

Deadlines are moved to the next business day if they fall on a weekend or state holiday.

V. Other Questions

1. How and under what circumstances is individual information released?

ANSWER: All filings are available to the public via the online searchable database on the Council website for five years.

2. Are filers notified when their disclosure forms are requested and released?

ANSWER: There is no requirement that the filer be notified that the information has been requested.

3. Is personal information released when a disclosure statement is requested?

ANSWER: The Council redacts residential addresses, personal telephone numbers, and email addresses from your form before making them public on the database.

4. What training is required?

ANSWER: State filers are required to complete training at least once every two years. New state filers must complete the training within two months after beginning their employment or assuming office.

Contact Information:

Virginia Conflict of Interest and Ethics Advisory Council
201 North 9th Street
4th Floor
Richmond, VA 23219
Website: ethics.dls.virginia.gov
Email: ethics@dls.virginia.gov

Stewart Petoe
Executive Director
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Jake Mullican
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804.698.1836

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee

DRAFT MINUTES

DECEMBER 10, 2025

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

1220 BANK STREET, RICHMOND, VIRGINIA 23221

This meeting was held in person with electronic or phone connection available.

MEMBERS PRESENT: Jane McDonald, Cindy Lamb, Rebecca Graser

DBHDS STAFF PRESENT: Madelyn Lent, Public Policy Manager
Meghan McGuire, Deputy Commissioner, Policy and Public Affairs
Nathan Miles, Chief Financial Officer
Eric Billings, Director of Fiscal Services and Grants Management (virtual)
Chaye Neal-Jones, Director, Office of Enterprise Management Services
Crystal Lipford, Director of Quality and Risk Management, Division of Facility Services (virtual)

I. Call to Order

II. Welcome and Introductions

Jane McDonald called the meeting to order at 8:39 am.

III. Adoption of Agenda, December 10, 2025

Cindy Lamb moved to adopt the agenda. Rebecca Graser seconded. The agenda was adopted unanimously.

IV. Adoption of Minutes, September 24, 2025

Cindy Lamb moved to adopt the minutes. Rebecca Graser seconded. The minutes were adopted unanimously.

V. Review Policy Plan for FY2025 - FY2030

Madelyn Lent presented revisions to the policy plan to delay future scheduled reviews by one meeting cycle and adjust the sequence of review for some of the Chapter 1: System Mission and Direction policies to better align reviews of closely related policies. Cindy Lamb moved to adopt the revision to the policy plan. Rebecca Graser seconded. The revision to the policy plan was adopted unanimously.

VI. Introduce Draft Revisions

The committee continued discussion of proposed revisions to Policy 3000 (CO) 74-10, Appointments of Department Employees to Community Services Boards. Field review comments received from Community Services Boards on proposed revisions were presented.

The committee continued discussion of Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards. The committee reviewed additional background information and data as requested by members at the September meeting

and an initial draft of DBHDS recommended revisions for this policy. During the discussion it was noted that the data presented on retained balances were self-reported by CSBs as the Department does not have direct access to CSB financial systems. Proposed revisions to Policy 6005 will be sent to Community Services Boards for field review prior to the April 2026 committee meeting.

VII. Presentation of draft revisions for recommendation to the full board

The committee reviewed draft revisions recommended by the Department for Policy 2011 (ADM) 88-3, Naming of Buildings, Rooms, and Other Areas at State Facilities at the September meeting. Rebecca Graser moved to recommend revisions to the full Board. Cindy Lamb seconded. The revisions for Policy 2011 were recommended unanimously.

VIII. Next Quarterly Meeting: December 10, 2025.

IX. Adjournment

Jane McDonald adjourned the meeting at 9:13 am.

All current policies of the State Board are here:
https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee

AGENDA AS ADOPTED

APRIL 22, 2026

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE

3302 GALLOWS ROAD, FALLS CHURCH, VA 22042

This meeting will be held in person with a physical quorum present, with electronic or phone connection available.

I. Call to Order

II. Welcome and Introductions (5 min)

III. Adoption of Agenda, April 22, 2026

IV. Adoption of Minutes, December 10, 2025

V. Review Policy Plan for FY2025 - FY2030 (5 min)

VI. Presentation of Background Reviews (15 min)

The committee will review background information on the next policies scheduled for periodic review: Policy 1030 (SYS) 90-3 Consistent Collection and Utilization of Data in State Facilities and Community Services Boards and Policy 1040 (SYS) 06-3 Involvement and Participation of Individuals Receiving Services and Family Members.

VII. Presentation of draft revisions for recommendation to the full board (25 min)

The committee reviewed draft revisions recommended by the Department for Policy 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards and field review comments received from Community Services Boards at the December meeting. Revisions will be presented for the committee to vote on recommendation to the full board.

The committee reviewed draft revisions recommended by the Department for Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards and data requested by the committee. The committee will review comments received from Community Services Boards on the revisions recommended by the Department. Revisions will be presented for the committee to vote on recommendation to the full board. *(Please note if the committee recommends the policy to the state board and the board adopts the policy at their July meeting, the policy would become effective for the FY 2028 performance contract cycle.)*

VIII. Next Quarterly Meeting: July 15, 2026.

IX. Adjournment

All current policies of the State Board are here: https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/.

Renewed: 05/87
Renewed: 03/22/89
Renewed: 09/25/91
Updated: 10/29/03
Updated: 12/06/11
Updated: ??/??/????

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards

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Authority

Board Minutes Dated: September 25, 1974
Effective Date: September 25, 1974
Approved by Board Chairman: s/Richard M. Gillis.

References

§ 37.2-203, § 37.2-304, § 37.2-500, § 37.2-501 § 37.2-601, and § 37.2-602 of the Code of Virginia (1950)

Background

Originally, the Board received a number of inquiries about the appointment of an employee of the Department to a community services board. Also, concerns were raised regarding possible perceptions of conflicts of interest if Department employees served on CSBs. In response to these concerns, the Board adopted this policy.

Section 37.2-203 of the Code of Virginia authorizes the Board to adopt policies governing the operation of state hospitals, training centers, and community services boards and behavioral health authorities. Section 37.2-304 authorizes the Commissioner to supervise and manage the Department and its state facilities. Sections 37.2-500 and 37.2-601 authorize the establishment of community services boards and behavioral health authorities, hereafter referred to as CSBs. Finally, § 37.2-501 and § 37.2-602 govern the appointment of CSB board members by the governing bodies of the cities and counties that established the CSBs. Those two Code sections do not address appointments of Department employees to CSBs. Consequently, because appointments to CSBs are made by local governments rather than CSBs, those appointments are not under the purview of the Board's policy authority. However, the Board may adopt policy that directs the Department to ensure that its employees do not accept appointments as CSB board members.

Purpose

To prohibit Department employees from accepting appointments as CSB board members.

Policy	It is the policy of the Board that the Department, in order to avoid any appearance of impropriety or conflict of interest, shall ensure that members of its ~~classified employees~~ *workforce* shall not accept appointments as CSB board members. *For the purposes of this policy, the term workforce references all classified and wage employees as well as any contractor or subcontractor who has received compensation under a paid contract with DBHDS within the preceding twelve (12) months.*

Updated: 07/26/2011
Updated: 07/17/2019
Updated: ??/??/????

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 6005(FIN)94-2 Retention of Unspent State Funds by Community Services Boards

Authority

Board Minutes Dated: July 27, 1994
Effective Date: July 1, 1994
Approved by Board Chairman: James G. Lumpkin

References

Realizing the Vision: Barriers to an Integrated System, Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993
State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts
Community Services Performance Contract
§§ 37.2-508, ~~and §~~ 37.2-509, 37.2-608 and 37.2-611 of the Code of Virginia (1950)

Supercedes

STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training

Background

Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation.

Realizing the Vision: Barriers to an Integrated System, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.

Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation.

The Code of Virginia §§37.2-508 and 37.2-608 outlines the performance contract as the identified contracting mechanism the Department shall use to develop and

initiate negotiation of community services requirements, oversight and monitoring of all state-controlled funds awarded to the community services boards.

State Board POLICY 4018 (CSB) 86-9 Community Services Performance Contracts recognizes the community services performance contract as the primary accountability mechanism between the Department and individual CSBs. The performance contract governs unspent balances with detail and enforceability while incorporating substantive protections to both prevent future deficits and limit accrual of funds to support effective and efficient allocations of resources.

Purpose

To ~~establish~~ *define* the ability of CSBs to retain balances of unspent state general funds *through the performance contract process*.

Policy

It is the policy of the Board that:

- *requirements for unspent fund balances for state general funds must be defined in the performance contract and changes must be negotiated through the Department's performance contract process in collaboration with the CSBs. The performance contract may:*
    - ~~the Department shall~~ allow CSBs to retain balances of unspent state general funds after the end of the fiscal year in which the Department granted those funds;
    - *define the maximum acceptable amount of each unspent state fund balance that a CSB may accumulate and define the maximum total accumulation of state funds.*
    - *define the process for unspent balances to be expended in accordance with spending plans to be established between the Department and CSB.*
- the Department ~~shall~~ *may* allocate the funds in the CSB state appropriation ~~without~~ applying estimated year-end balances of unspent state general funds to the next year's CSB awards of state general funds *as permitted under §§ 37.2-509 and 37.2-611 after consultation with the CSB to ensure mutual awareness and understanding of the impact to the budget of the CSB;*
- ~~based on~~ *Pursuant to* the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a result of a CSB's retention of any balances of unspent state general funds; and
- *i*~~I~~f a CSB ~~delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to §§ 37.2-~~

~~508 of the Code of Virginia and State Board Policy 4018, while~~ generat~~esing~~ significant balances of unspent state general funds*, and is not able to develop a viable spending plan in collaboration with the Department,* it may have to return ~~some~~ *a portion or all* of its balances to the Department or its state fund allocations in the next fiscal year may be reduced. *The Department shall consult with the CSB prior to taking action to ensure mutual awareness and understanding of the impact of the proposed action to the budget of the CSB.*

~~It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.~~

Finally, it is the policy of the Board that the Community Services Performance Contract shall contain principles and procedures for the more effective and consistent utilization of unexpended state general fund balances from previous fiscal years by CSBs.

State Board of Behavioral Health and Developmental Services
Policy Development and Evaluation Committee
April 22, 2026
COMMENTS ON ONE POLICIES: ONE WINDOW (OCTOBER 31 - NOVEMBER 24)

Policy:	DBHDS Recommended Revisions to Policy 6005 (CO) 74-10 Appointments of Department Employees to Community Services Boards
Window:	**January 8 – March 13**

Date Rcv'd	Contact	Comment
01/14/2026	Michael Goodrich Assistant Director-Administration Prince William	Any funds retained by a CSB should be percentage based, not dollar based. DBHDS should be permitted to keep an administrative fee no larger than the federal indirect cost percentage to administer the year over year carryover. However, the CSB should be able to carry over the funds to provide services to its catchment area.
02/25/2026	Kyle Vaught ES Director Crossroads	Would this policy include the state retroactively reclaiming unspent funds previously awarded?
03/03/2026	Brandie Williams Deputy Executive Director Rappahannock Area CSB	Thank you for inviting comment on the proposed updates to Policy 6005 related to the treatment of unexpended state general funds by Community Services Boards (CSBs). To support the Department's consideration of stakeholder input, the Virginia Association of Community Services Boards (VACSB) has submitted a redlined draft identifying recommended edits and clarifications. The policy as currently written properly affirms that CSBs are allowed to carry forward unspent state general fund balances and that those funds should not be routinely or automatically used to reduce subsequent allocations. As revisions move forward, I recommend incorporating the additional refinements outlined in the VACSB redline so the policy more fully aligns with existing statutory authority and present-day operating practices. First, the revised policy should more clearly identify the Community Services Boards collaboration and input when setting expectations regarding unencumbered state general fund balances, including guidance on reserve levels and spending plan requirements. The policy should outline a collaboration framework which strengthens shared understanding, promotes transparency, and reinforces mutual accountability. Second, the policy should explicitly call for engagement with any affected CSB before projected year-end balances are applied toward future funding, funds are recaptured, or subsequent state allocations are adjusted. When sizable balances are identified, a collaborative process to establish an appropriate and workable spending plan supports financial stability and upholds the cooperative relationship between the Department and CSBs. Thank you

		again for the opportunity to provide input on these proposed changes.
03/11/2026	Kevin Mullins Executive Director Dickenson County Behavioral Health	Comment Regarding Proposed Changes to Policy 6005 (FIN) 94-2 – Retention of Unspent State Funds Thank you for the opportunity to provide comment regarding potential modifications to Policy 6005 (FIN) 94-2 and the proposal to limit retained balances by reducing future warrant payments until those balances reach an "acceptable" level. As the Executive Director of one of the smallest Community Services Boards in the Commonwealth, I would like to emphasize the importance of maintaining reasonable operating reserves to ensure the continuity of essential behavioral health services. For many CSBs—particularly smaller and rural boards—retained state funds function as necessary working capital rather than idle balances. These reserves allow organizations to manage fluctuations in revenue, respond to service demands, and maintain continuity of care during periods of delayed or interrupted funding. Because CSBs operate critical safety-net services, including crisis response and behavioral health treatment, maintaining financial stability is essential to ensuring that services remain available without interruption. A policy that automatically reduces warrant payments until retained balances are reduced could unintentionally create cash-flow challenges. This concern is particularly relevant for smaller CSBs that operate with limited financial flexibility and fewer alternative funding sources. Reasonable reserves allow CSBs to meet payroll obligations, maintain service capacity, and continue operations during periods when state payments or other funding streams may be delayed. If changes to the policy are being considered, it would be helpful for the Commonwealth to clearly define what constitutes an "acceptable" reserve balance. Establishing objective guidelines—such as a percentage of operating expenses or a reasonable number of months of operating reserves—would promote fiscal accountability while still allowing CSBs to responsibly manage their finances. Additionally, consideration should be given to differences in size and financial capacity among CSBs. Smaller boards may require proportionally greater reserves to maintain operational stability, and a uniform standard could disproportionately affect rural or smaller service areas. The original intent of Policy 6005 recognized the importance of allowing CSBs to retain unspent funds in order to responsibly manage service delivery across fiscal years. Preserving that flexibility, while establishing reasonable guardrails for reserve levels, would maintain both fiscal accountability and the stability necessary to deliver critical behavioral health services across the Commonwealth. Thank you for the opportunity to provide input on this important matter.
03/11/2026	Ivy Sager Executive Director Hanover CSB	Please refer to the redlined document from VACSB reflecting suggested changes and clarifications to this proposed policy. Hanover CSB supports the edits reflected in the redlined version. Those revisions appropriately clarify the retention of unencumbered funds by CSBs and reinforce the Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan

		expectations. Thank you for the opportunity to provide input.
03/12/2026	Kim Shaw Executive Director Rockbridge	Consideration of waivers for the 25% carry-over allowance for restricted funds, IF DBHDS with unnecessary internal (not state or federal guidelines) are the reason for the delay in spending.
03/12/2026	Connie Barnes Financial Officer VA Beach CSB- Department of Health Services	CSBs utilize carryover funding as a necessary stabilizer against economic volatility and escalating operational requirements. These reserves are essential for addressing unpredictable shifts in the economic landscape, particularly regarding the recruitment and retention of high-quality personnel. Furthermore, as the costs for client-facing essentials—such as housing and utilities—continue to rise, the ability to retain unspent balances remains vital. While our preference is to maintain the current carryover model, we strongly advocate for an increase in the allowable percentage to ensure long-term fiscal sustainability.
03/13/2026	Anna Jones Quality Assurance Manager Henrico Area Mental Health and Developmental Services	Henrico Area Mental Health and Developmental Services appreciates the opportunity to comment on the proposed revisions to Policy 6005 regarding retention of unspent state general funds by Community Services Boards. For reference, a VACSB redlined document reflecting suggested clarifications has been shared with DBHDS to assist in its review of submitted comments. The current policy appropriately establishes that CSBs may retain balances of unspent state general funds and that those balances should not automatically be applied to reduce future allocations. As the Board considers revisions, we encourage additional clarifications as outlined in the VACSB redline document to better reflect current statutory authority and operational practice. First, the policy should clearly reinforce the Community Services Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan expectations. Anchoring these requirements in the performance contract supports collaboration, accountability, and transparency. Second, the policy should clearly emphasize consultation with the impacted CSB before applying estimated year-end balances to future allocations, retrieving funds, or reducing future state allocations. Providing an opportunity to collaboratively develop a viable spending plan when significant balances exist promotes fiscal stability and reinforces the partnership between the Department and CSBs. Finally, the policy should continue to reflect the General Assembly's prohibition against supplanting local matching funds with retained state balances. Continued clarity on this point is important to preserve the integrity of the state-local funding structure. Thank you for the opportunity to provide input.
03/13/2026	Terrelle Stewart Executive Director	I appreciate the opportunity to comment on the proposed revisions to Policy 6005 regarding retention of unspent state general funds by Community Services Boards. For reference, a

	Greater Reach Community Services Board (formerly known as District 19 Community Services Board)	VACSB redlined document reflecting suggested clarifications has been shared with DBHDS to assist in its review of submitted comments. The current policy appropriately establishes that CSBs may retain balances of unspent state general funds and that those balances should not automatically be applied to reduce future allocations. As the Board considers revisions, I encourage additional clarifications as outlined in the VACSB redline document to better reflect current statutory authority and operational practice. First, the policy should clearly reinforce the Community Services Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan expectations. Anchoring these requirements in the performance contract supports collaboration, accountability, and transparency. Second, the policy should clearly emphasize consultation with the impacted CSB before applying estimated year-end balances to future allocations, retrieving funds, or reducing future state allocations. Providing an opportunity to collaboratively develop a viable spending plan when significant balances exist promotes fiscal stability and reinforces the partnership between the Department and CSBs. Significant federal Medicaid eligibility changes will be effective next year. The changes add a work requirement for certain individuals currently receiving Medicaid. Many individuals receiving CSB services are Medicaid recipients and will likely be subject to the new work requirements. Some of these individuals may not understand or be able to comply with the new requirements. As a result, individuals will lose Medicaid eligibility and CSBs will no longer receive Medicaid reimbursement for critical services. CSBs must continue to provide essential services to individuals who lose Medicaid eligibility; the result will be a funding gap for critical services provided by CSBs. The DBHDS proposal to cap unspent funds is a dramatic departure from the current budgeting process. A change of this magnitude must allow for careful evaluation of the impact of any unspent funding on the Virginia Community Services Board system as a whole and on each CSB. A reasonable approach would be to continue the current budgeting process, allow unspent funding to be carried forward into 2028and concurrently assess the impact of the Medicaid work requirement on current and future Medicaid funding and reimbursements for individuals receiving services through CSBs. Finally, the policy should continue to reflect the General Assembly's prohibition against supplanting local matching funds with retained state balances. Continued clarity on this point is important to preserve the integrity of the state-local funding structure. Thank you for the opportunity to provide input.

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 6005(FIN)94-2 Retention of Unspent State Funds by Community Services Boards

Authority

Board Minutes Dated: July 27, 1994
Effective Date: July 1, 1994
Approved by Board Chairman: James G. Lumpkin

References

Realizing the Vision: Barriers to an Integrated System, Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993
State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts
Community Services Performance Contract
§§ 37.2-508, ~~and §~~ 37.2-509, 37.2-608 and 37.2-611 of the Code of Virginia (1950)

~~Supercedes~~**Supersedes** STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training

Background

Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation.

Realizing the Vision: Barriers to an Integrated System, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. ~~The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.~~

Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation.

Since that time, there have been many system and administrative impacts that now require a shift in this policy. Remaining at the core is the shared vision outlined in the Partnership Agreement that there is "a common desire for the public system of care to excel in the delivery and seamless continuity of services to individuals receiving services and their families."

The Code of Virginia §§37.2-508 and 37.2-608 outlines the performance contract as the identified contracting mechanism the Department shall use to develop and

Commented [IS1]: Consider changing this word to "unencumbered" consistent with other changes in document

Commented [IS2]: This information should not be removed. It provides historical/background context. The proposed policy change doesn't change this history. Added language that indicates why there is a shift now but keeps the historical context.

initiate negotiation of community services requirements, oversight and monitoring of all state-controlled funds awarded to the community services boards. This is an annual collaborative process that ensures both parties have input on this important document that drives and operationalizes the shared vision.

State Board POLICY 4018 (CSB) 86-9 Community Services Performance Contracts recognizes the community services performance contract as the primary accountability mechanism between the Department and individual CSBs.

The performance contract ~~governs unspent~~ provides a framework to address unencumbered balances with detail and enforceability while incorporating substantive protections to both prevent future deficits and limit accrual of funds to support effective and efficient allocations of resources.

Purpose

To ~~establish~~ ~~*define*~~ *provide the framework for* ~~the ability of~~ CSBs to retain balances of ~~unspent~~ unencumbered state general funds~~.~~ ~~*through the performance contract process.*~~

Policy

It is the policy of the Board that:

- *requirements for ~~unspent~~ unencumbered fund balances for state general funds must be defined in the performance contract and changes must be negotiated between the Department and the CSBs as part of the annual review process. ~~through the Department's performance contract process in collaboration with the CSBs~~. The performance contract may:*
    - ~~the Department shall~~ allow CSBs to retain balances of ~~unspent~~ unencumbered state general funds after the end of the fiscal year in which the Department granted those funds *in a reserve fund*;
    - *define the maximum acceptable amount of each ~~unspent~~unencumbered state fund balance that a CSB may accumulate in reserve funds and define the maximum total accumulation of state funds in reserve;*
    - *allow flexibility in spending from the reserve fund with an agreed upon spending plan between the Department and CSB.*~~-~~
- the Department ~~shall~~ *may* allocate the funds in the CSB state appropriation ~~without~~ applying estimated year-end balances of ~~unspent~~ -unencumbered state general funds to the next year's CSB awards of state general funds *as permitted under §§ 37.2- 509 and 37.2-611 but may only do so after consulting with the CSB in order to not negatively impact that CSBs budget and/or cash flow*;
- ~~based on~~ ~~*P*~~*pursuant to* the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a

result of a CSB's retention of any balances of ~~unspent~~ unencumbered state general funds; and

- ~~*i*~~If a CSB ~~delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to §§ 37.2-508 and 37.2-608 of the Code of Virginia and State Board Policy 4018, while~~ generates~~ing~~ significant balances of ~~unspent~~ unencumbered state general funds, and is not able to develop a viable spending plan in collaboration with the Department, it may have to return ~~some~~ *a portion or all* of its balances to the Department or its state fund allocations in the next fiscal year may be reduced. No action will be taken without direct consultation with the impacted CSB.

Commented [IS3]: This should be removed as the "levels of service" language no longer applies in the same way with the new data systems and dashboard.

~~It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.~~

Finally, it is the policy of the Board that the Community Services Performance Contract shall contain principles and procedures for the more effective and consistent utilization of ~~unexpended~~ unencumbered state general fund balances from previous fiscal years by CSBs.

State Board of Behavioral Health and Developmental Services

Planning and Budget Committee

AGENDA AS ADOPTED

WEDNESDAY, APRIL 22, 2026

Northern Virginia Mental Health Institute
3302 Gallows Road, Falls Church, VA 22042

Meeting is in person with a physical quorum present; however, electronic meeting access is available.

I.	**CALL TO ORDER**
	A. Determination of Quorum B. Welcome and Introductions C. Adoption of Agenda
II.	**REVIEW MEETING PLAN FOR 2026-28 BIENNIUM**
III.	**REVIEW BOARD BYLAWS ARTICLE VIII**
	ARTICLE VIII. Liaison Assignments Pursuant to § 37.2-203 of the Code of Virginia, the Board shall ensure that programs to educate Virginians about and elicit public support for the activities of the Department, state facilities, community services boards, and behavioral health authorities are initiated by the Department. The Board seeks to further the integration and coordination of services to individuals receiving services and to support, encourage, and build close working partnerships among community services boards and behavioral health authorities, state facilities, and the Department. The Board also seeks to enhance its knowledge and understanding of the wide diversity of community and state facility services across the Commonwealth and to develop and maintain connections with entities in the public behavioral health and developmental services system. The Chair, in consultation with Department staff, may develop a list for each Board member of agencies and organizations with which the Board wishes to liaise, including state facilities, the Virginia Association of Community Services Boards, community services boards and behavioral health authorities, and the State Human Rights Committee. The Chair shall appoint members of the Board to serve as liaisons with these agencies and organizations, recognizing the time constraints of members and that each member may fulfill Board member liaison responsibilities in different ways. Board member liaisons shall report successes, issues, and concerns to the Board at its regular meetings and to appropriate Department staff. Board member liaisons shall confer or meet regularly with groups to which they are assigned and report to the full Board as necessary.
IV.	**ANNOUNCEMENTS**
	Next meeting is scheduled for July 15, 2026.
IV.	**ADJOURNMENT**

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* Prior committee meeting minutes from April 2, 2025, approved by full board at its meeting July 9, 2025.

State Board of Behavioral Health and Developmental Services

Meeting Plan for 2026-28 Biennium

QUARTERLY MEETING	STANDING AGENDA ITEMS *Bylaws requirements in italics*	ADDITIONAL PRESENTATION TOPICS
2026		
SPRING April 22, 2026 Falls Church	• Post-Session Legislative & Budget Review • VACSB Update • Facility Tour and Overview	• Certified Recovery Residences • Communications and Outreach
SUMMER July 15, 2026 Burkeville	• *Officer Elections* • *Annual Meeting Schedule Adoption* • VACSB Update • Facility Tour and Overview	TBD – Refer to Biennial Priorities
FALL Sept. 23, 2026 Catawba	• *Quadrennial Review of Bylaws* • Office of Human Rights Update • VACSB Update • Facility Tour and Overview	TBD – Refer to Biennial Priorities
WINTER Dec. 9, 2026 Richmond	• *Annual Electronic Meetings Policy Review* • Pre-Session Legislative & Budget Overview • Federal Grants Update • VACSB Update	TBD – Refer to Biennial Priorities
2027		
SPRING April 21, 2027 Marion	• Post-Session Legislative & Budget Review • VACSB Update • Facility Tour and Overview	TBD – Refer to Biennial Priorities
SUMMER July 14, 2027 Richmond or Petersburg*	• *Officer Elections* • *Annual Meeting Schedule Adoption* • *Biennial Planning Meeting* • VACSB Update • Facility Tour and Overview (if offsite)*	TBD – Refer to Biennial Priorities
FALL Date TBD Location TBD	• Office of Human Rights Update • VACSB Update • Facility Tour and Overview	TBD – Refer to Biennial Priorities
WINTER Date TBD Richmond	• Biennial COIA Training • *Annual Electronic Meetings Policy Review* • Pre-Session Legislative & Budget Overview • Federal Grants Update • VACSB Update	TBD – Refer to Biennial Priorities

We urge strategic continuity in the 2026-28 biennium, with special emphasis on crisis care, community supports, competency restoration, and the youth continuum. In particular, the board endorses:

1. **Expanding system capacity, building on workforce sustainability investments, and increasing community-based services, including support for Virginians with substance use disorders.**

2. **Reducing overreliance on law enforcement, especially through utilization of crisis care, and decreasing the "criminalization" of behavioral health conditions.**
   - Increase the use of special conservators of the peace (SCOPs) for alternative custody and transportation.
   - Advance technologies that help crisis workers access and share information for more effective triage.

3. **Financing waiver services and sustaining provider rates to ensure the availability and long-term success of integrated community settings for Virginians with developmental disabilities and their families.**

4. **Accelerating expansion of the community-based crisis continuum, which has shown the greatest impact on delivering effective treatment to the Commonwealth's most vulnerable populations.**
   - Provide additional support to build out the elements of the MARCUS Alert system that have proven to be effective, most notably crisis co-response teams and enhanced communication protocols, and other immediate crisis services (CITAC, CRCs, etc.).
   - Review and consider repealing or amending the Bed of Last resort Law to correct significant unintended consequences that overburden the state hospital system, law enforcement, community services boards, and many other system partners.

5. **Prioritizing a comprehensive system of care to identify and meet the needs of Virginia's infants, children, adolescents, and young adults as early as possible.**
   - Maintain support for Early Intervention, school-based, and other youth services.
   - Promote the Virginia Mental Health Access Program (VMAP) and other training resources for child-serving providers to serve behavioral health concerns.
   - Incentivize private sector partners to increase access to mental health support services for children from birth to transition age.

UNFINISHED BUSINESS

Consideration of amendments recommended by the Policy and Evaluation Committee to update and operationalize Policy 2011 (ADM) 88-3 while maintaining core requirements.

Included in Agenda Packet:

- Policy 2011 (ADM) 88-3 – Naming of Buildings, Rooms, and Other Areas at State Facilities

Renewed: 09/25/91
Updated: 02/27/95
Updated: 10/29/03
Updated: 12/06/11

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 2011 (ADM ST BD) 88-3 Changing the Names of State Facilities

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Authority

Board Minutes Dated: June 22, 1988
Effective Date: August 24, 1988
Approved by Board Chairman: s/James C. Windsor

References

§ 37.2-203 of the Code of Virginia (1950)

Background

The *State* Board *of Behavioral Health and Developmental Services (the "Board")* has a long history of naming buildings at state hospitals and training centers, hereafter referred to as state facilities, operated by the Department. In 1981, the Board asked the Department to propose a statement that would establish the Board's policy for naming buildings at state facilities and the procedure for implementing that policy. In 1988 the original policy was revised to include rooms and other areas, e.g. recreational areas, under the purview of the policy. *In 2025, the policy was revised to modernize language, clarify stakeholder engagement requirements, and align procedures with current best practices in governance, transparency, and community involvement. It also updated timelines, documentation requirements, and responsibilities to ensure consistency across state facilities.*

Subsection 9 of § 37.2-203 of the Code of Virginia authorizes the Board "to change the names of state facilities." This policy sets forth the procedures by which such changes may occur.

Purpose

~~To describe the role of the in changing the names of state facilities.~~ *To establish the official process for changing the names of state facilities under the jurisdiction of the Board, ensuring decisions are transparent, inclusive, and consistent with statutory authority.*

Policy

It is the policy of the Board that it may change the name of any state facility ~~as~~

~~authorized~~ in *accordance with the authority granted under § 37.2-203(9) and the following procedures:* ~~subsection 9 of § 37.2-203 of the Code of Virginia, and shall do so in accordance with the following procedures.~~

1. ***Initiation of Renaming***
    a. *A name change proposal should be considered when one or more of the following apply:*
        i. *The existing name is no longer reflective of the facility's mission, services, or population served.*
        ii. *The current name is outdated, contains historical associations now judged inappropriate, or causes confusion.*
        iii. *To honor an individual (living or deceased) whose contributions to behavioral health, disability services, or the facility / community are outstanding and enduring.*
        iv. *Community identity, location, or other geographic naming considerations make a change desirable.*
        v. *Other extenuating circumstances as documented and evaluated.*
    b. *A name change may only be considered when deemed appropriate by the facility director, the Commissioner, and the Secretary of Health and Human Resources (the Secretary).*

2. ***Formation of Ad Hoc Committee***
    a. *When a name change is deemed appropriate by the facility director, the Commissioner, and the Secretary, the facility director shall appoint an ad hoc committee of at least three members to develop the formal proposal.*
    b. *The committee shall include the following elements in the proposal:*
        i. *Current name and rationale for the renaming proposal*
        ii. *Proposed new names, each with a written explanation and justification*
        iii. *Input or feedback collected from stakeholders*
        iv. *Any cost estimate associated with renaming*
        v. *Potential impact on operations, identity, or community perception*

3. ***Facility Director Review***
    a. *The facility director shall review, approve, or revise the proposal and forward to the Commissioner.*

4. ***Commissioner Review***
    a. *The Commissioner shall approve, revise, or disapprove the proposal.*
    b. *If approved or revised, the Commissioner shall forward the proposal to the Board at least 120 days prior to a regularly scheduled Board meeting.*
    c. *If disapproved, the Commissioner shall notify the facility director and provide a summary of the reason for the denial.*

5. ***Consultation Period***
    a. *During the 120-day period, the Commissioner and the Chair of the Board may consult with stakeholders. Stakeholders may include:*
        i. *Individuals receiving services*
        ii. *Family members*
        iii. *Advocacy groups*
        iv. *Local governments*
        v. *State legislators*
        vi. *Others as deemed appropriate*

6. ***Secretary Input***
    a. *The Commissioner and the Chair shall consult with the Secretary to obtain input on the proposed new name.*

7. ***Board Action***
    a. *Following the Commissioner's recommendation, the Board will place the renaming proposal on its agenda.*
    b. *At a regularly scheduled Board meeting, the Board shall consider the recommendations and vote whether to approve the proposed facility name change.*

8. ***Implementation***
    a. *Upon Board approval, the facility director will develop a timeline for implementing the name change, including:*
        i. *Signage replacement*
        ii. *Updating documents and websites*
        iii. *Communications to internal and external stakeholders*

9. ***Records and Reporting***
    a. *All proposals, justifications, and decisions shall be documented and retained by DBHDS.*
    b. *The Commissioner shall report annually to the Board if any renaming activity occurs.*

- ~~The state facility director shall appoint an ad hoc committee of three or more members to develop a list of three recommendations of new names for the facility when it is deemed appropriate by the facility director, the Commissioner, and the Governor to change the name of the state facility.~~

- ~~The ad hoc state facility committee shall develop a brief explanation and justification for each of the names it recommends.~~

- ~~The state facility director shall review and approve or revise the ad hoc committee's recommendations and forward them to the Commissioner for his review and action.~~

- ~~The Commissioner shall approve, revise, or disapprove the recommendations. If he approves or revises them, he shall forward the recommendation or recommendations to the Board at least 120 days prior to a regularly scheduled board meeting.~~

- ~~The Commissioner and the Chair of the Board shall discuss the proposed new name to come to agreement on recommendations to send to the Governor. The Commissioner and the Chair may consult with other interested or affected parties, including individuals receiving services, family members, advocacy groups, local governments, and state legislators, about the recommended new name during the 120 day period.~~

- ~~The Commissioner and the Chair of the Board shall communicate and consult with the Governor to obtain his input on the proposed new name.~~

- ~~The Board shall consider the recommendation and take action on the recommendation to change the name of the state facility at a regularly scheduled board meeting.~~

REGULATORY BUSINESS

REVISED Emergency/NOIRA Action
*Align Licensing Regulations with **recent DMAS revisions to** Redesigned Medicaid Service: Coordinated Specialty Care (CSC)*

Included in Agenda Packet:

- DRAFT Agency Background Document (TH-05)
- DRAFT Amendments to DBHDS Licensing Regulations (12VAC35-105)

Background:
Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. The General Assembly directed the board to align DBHDS Licensing Regulations with the modifications being made to Medicaid behavioral health services.[1]

At its meeting on December 10, 2025, the board voted to develop emergency regulations[2] to ensure consistency with the newly funded Medicaid services for **Coordinated Specialty Care (CSC)** based on the draft DMAS policy *at that time*.

The goal of CSC is to provide comprehensive, recovery-oriented treatment for individuals experiencing a first episode of psychosis. CSC aims to improve the quality of life and social and clinical outcomes for individuals served by offering a team-based approach that includes collaborative treatment planning, individual and family therapy, medication management, and support for education and employment goals.

Justification:
On March 26, 2026, DMAS announced significant CSC policy changes:

- https://www.dmas.virginia.gov/media/i0cewinx/dmas-coordinated-specialty-care-policy-change-summary.pdf.

This action conforms to those changes because consistency with DBHDS licensing regulations is important for licensed providers as well as for individuals receiving services and their families.

Action Needed:
Authorize a revised Emergency/NOIRA action to align the Licensing Regulations with redesigned Medicaid services for Coordinated Specialty Care (CSC), as reflected in the most recently issued DMAS draft provider manual. (A standard regulatory action to establish permanent regulations will follow this emergency action.)

Also, direct staff to withdraw the board's previously authorized CSC action.

[1] Item 293 B of the 2024-26 Appropriation Act.
[2] Refer to this flowchart for more information about the emergency regulatory process.

townhall.virginia.gov

Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	Alignment with Medicaid behavioral health services redesign; Coordinated specialty care (CSC)
Date this document prepared	April 6, 2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

The Department of Behavioral Health and Developmental Services (DBHDS) was directed by the General Assembly within Item 293 of the 2024-2026 Appropriations Act to utilize emergency authority to align licensing regulations with the modifications being made to Medicaid behavioral health services in accordance with Item 288. Item 288 requires the Department of Medical Assistance Services (DMAS) to:

> *XX. 1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation,*

Intensive In Home Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services.

To comply with the General Assembly mandate, DBHDS will enact three separate emergency regulatory actions to align the DBHDS Licensing Regulations with the changes to Medicaid, by removing provisions that would conflict with newly funded behavioral health services and by establishing new licensed services for Community Psychiatric Support and Treatment (CPST), Coordinated Specialty Care (CSC), and Clubhouse. This regulatory action will establish the newly licensed service of CSC.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

Coordinated Specialty Care (CSC)
Department of Behavioral Health and Development Services (DBHDS)
Department of Medical Assistance Services (DMAS)

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.
b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

The 2025 General Assembly, per Item 293 of the 2024-2026 Appropriations Act, directed DBHDS to promulgate emergency regulations to align licensing regulations with the modifications being made to Medicaid behavioral health services. A regulatory action to establish permanent regulations will follow this emergency action.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS was directed by the General Assembly through the 2024-2026 Appropriations Act to promulgate emergency regulations that align its licensing regulations with the modifications being made to Medicaid behavioral health services. Item 293 B of the 2024-2026 Budget Bill mandates the changes within this regulatory action.

Section 37.2-203 of the Code of Virginia gives the board the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner. The board voted to adopt this regulatory action at its meeting on _____.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this regulatory action is to comply with the legislative mandate by aligning DBHDS licensing regulations with changes to Medicaid by removing provisions that would conflict with newly funded behavioral health services. Specifically, this regulatory action will establish the newly licensed service of CSC.

The goal of CSC is to provide comprehensive and recovery-oriented treatment for individuals experiencing a first episode of psychosis. CSC aims to improve the quality of life and social and clinical outcomes for individuals served by offering a team-based approach that includes collaborative treatment planning, individual and family therapy, medication management, and support for education and employment goals.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) Definitions necessary for the integration of CSC into the Licensing Regulations;
2) Admission criteria for CSC;
3) Discharge criteria for CSC;
4) Minimum service delivery requirements for CSC; and
5) Minimum requirements for treatment teams and staffing.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring CSC providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to ensure consistency between DBHDS licensing regulations and DMAS modifications to Medicaid behavioral health services. Misalignment between the two would be problematic for licensed providers of behavioral health services, including small business providers, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the emergency regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions		Definitions for the Licensing Regulations.	Addition of the following terms: "Coordinated specialty care" or "CSC" means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions. "CSC rehabilitation skill-building" means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration. "Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105. "Health literacy support" means both (i) medication administration by licensed professional working within the scope of

			their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual. "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59. "Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Edits to the term: "Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical

			social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.			Addition of the license type: Coordinated specialty care. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices to provide person-centered treatment.
	12VAC35-105-1426. Admission Criteria		Intent: Provide clear admission requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1427. Discharge criteria.		Intent: Provide clear discharge requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

	12VAC35-105-1428. Service delivery		Intent: Provide clear service delivery requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1429. Treatment team and staffing.		Intent: Provide clear requirements to providers of CSC services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8524 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Alignment with Medicaid behavioral health services redesign; Coordinated Specialty Care (CSC)

12VAC35-105-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means, as defined by § 37.2-100 of the Code of Virginia, any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the individual;

4. Misuse or misappropriation of the individual's assets, goods, or property;

5. Use of excessive force when placing an individual in physical or mechanical restraint;

6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or the individual's individualized services plan; or

7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with the individual's individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"Brain injury" means any injury to the brain that occurs after birth that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" or "Level of care 3.5" means a substance use treatment program that offers 24-hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" or "Level of care 3.1" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed population specific high-intensity residential services" or "Level of care 3.3" means

a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Collaborative behavioral health services" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually 65 years of age or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health-related services.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Coordinated specialty care" or "CSC" means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical

social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis education and prevention plan" or "CEPP" means a department-approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and de-escalating problems in a healthy way and provide teaching skills that the individual can apply independently.

"Crisis planning team" means the team who is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team consists, at a minimum, of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

"Crisis receiving center," "CRC," or "23-hour crisis stabilization" means a community-based, nonhospital facility providing short-term assessment, observation, and crisis stabilization services for up to 23 hours. This service is accessible 24 hours per day, seven days per week, 365 days per year, and is indicated when an individual requires a safe environment for initial assessment and intervention. This service includes a thorough assessment of an individual's behavioral health crisis, psychosocial needs, and supports in order to determine the least restrictive environment most appropriate for stabilization. Key service functions include rapid assessment, crisis intervention, de-escalation, short-term stabilization, and appropriate referrals for ongoing care. This distinct service may be co-located with other services such as crisis stabilization units.

"Crisis stabilization" means direct, intensive nonresidential or residential care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Crisis stabilization unit," "CSU," or "residential crisis stabilization unit" is a community-based, short-term residential treatment unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities.

"CSC rehabilitation skill-building" means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An

individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or individual's authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Health literacy support" means both (i) medication administration by a licensed professional working within the scope of their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and the individual's authorized representative, as applicable, and the provider with the intent of empowering the individual and the individual's authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual or that individual's authorized representative to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety

needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, ~~or~~ licensed psychiatric/mental health nurse practitioner, or a licensed psychological practitioner.

"LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

"Location" means a place where services are or could be provided.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medically managed intensive inpatient service" or "Level of care 4.0" means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" or "Level of care 3.7" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided includes directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care provided may include the use of medication to address the effects of substance use. This service is appropriate for an individual whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the legally permitted direct application of medications, as enumerated by § 54.1-3408 of the Code of Virginia, by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication-assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication-assisted treatment includes medications for opioid use disorder as well as medications for treatment of alcohol use disorder.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication for opioid use disorder" or "MOUD" means medications, including opioid agonist medications, approved by the U.S. Food and Drug Administration for the use in the treatment of opioid use disorder.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time

to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

"Office of Human Rights" means the Department of Behavioral Health and Developmental Services Office of Human Rights.

"Opioid treatment practitioner" means a health care professional who is appropriately licensed to prescribe or dispense medications in Virginia for opioid use disorders and, as a result, is authorized to practice within an opioid treatment program.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified individual" means a named individual who (i) is at least 18 years of age; (ii) is a full-time employee or contractor of the provider; and (iii) has met the appropriate prerequisites as specified in 12VAC35-105.

"Qualified mental health professional" or "QMHP" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know.

"REACH crisis therapeutic home" or "REACH CTH" means a residential home with crisis stabilization REACH service for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"REACH mobile crisis response" means a REACH service that provides mobile crisis response for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Regional education assessment crisis services habilitation" or "REACH" means the statewide crisis system of care that is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing mental health or behavior crisis events that put the individuals at risk for homelessness, incarceration, hospitalization, or danger to self or others.

"Residential" or "residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent and requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, community gero-psychiatric residential, ICF/IID, sponsored residential homes, withdrawal management, and neurobehavioral services.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential treatment service" means providing an intensive and highly structured clinically based mental health, substance abuse, or neurobehavioral service for co-occurring disorders in a residential setting other than an inpatient service.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an

individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for initial assessment.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave the area.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

b. A bowel obstruction; or

c. Aspiration pneumonia.

"Level III serious incident" means a serious incident, whether or not the incident occurs while in the provision of a service or on the provider's premises, that results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means, as defined by § 37.2-403 of the Code of Virginia, (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication for opioid use disorder treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Signed" or "signature" means a handwritten signature, an electronic signature, or a digital signature, as long as the signer showed clear intent to sign.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State opioid treatment authority" or "SOTA" means the Virginia Department of Behavioral Health and Developmental Services, which is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opioid use disorder with MOUD.

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient service" or "Level of care 1.0" means a center-based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of

Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" or "Level of care 2.5" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Telehealth" shall have the same meaning as "telehealth services" in § 32.1-122.03:1 of the Code of Virginia.

“Telemedicine" shall have the same meaning as "telemedicine services" in § 38.2-3418.16 of the Code of Virginia.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

"Withdrawal management" means the dispensing of MOUD in decreasing doses to an individual to alleviate adverse physical effects incident to withdrawal from the continuous or sustained use of an opioid and as a method of bringing the individual to an opioid-free state within such a period. Long-term withdrawal management refers to the process of medication tapering that exceeds 30 days.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a

developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Assertive community treatment (ACT);
2. Case management;
3. Clinically managed high-intensity residential care or Level of care 3.5;
4. Clinically managed low-intensity residential care or Level of care 3.1;
5. Clinically managed population specific high-intensity residential or Level of care 3.3;
6. Community gero-psychiatric residential;
7. Community-based crisis stabilization;
8. Coordinated specialty care;
~~8.~~9. Crisis receiving center;
~~9.~~10. Crisis stabilization unit;
~~10.~~11. Day support;
~~11.~~12. Day treatment, including therapeutic day treatment for children and adolescents;
~~12.~~13. Group home and community residential;
~~13.~~14. ICF/IID;
~~14.~~15. Inpatient psychiatric;
~~15.~~16. Intensive in-home;
~~16.~~17. Medically managed intensive inpatient service or Level of care 4.0;
~~17.~~18. Medically monitored intensive inpatient treatment or Level of care 3.7;
~~18.~~19. Medication for opioid use disorder treatment;
~~19.~~20. Mental health community support;
~~20.~~21. Mental health intensive outpatient;
~~21.~~22. Mental health outpatient;
~~22.~~23. Mental health partial hospitalization;
~~23.~~24. Psychosocial rehabilitation;
~~24.~~25. REACH CTH;
~~25.~~26. REACH mobile crisis response;
~~26.~~27. Residential treatment;
~~27.~~28. Respite care;
~~28.~~29. Sponsored residential home;
~~29.~~30. Substance abuse intensive outpatient;
~~30.~~31. Substance abuse outpatient;
~~31.~~32. Substance abuse partial hospitalization;
~~32.~~33. Supervised living residential; and
~~33.~~34. Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

12VAC35-105-1426. Admission Criteria.

A. Before a CSC provider may admit an individual to the service, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies.

B. The policy regarding admission to CSC, shall at a minimum, meet the requirements of 12VAC35-105-650 and the assessment required by that section shall:

1. Be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Assessments completed by a LMHP-R, LMHP-RP or LMHP-S shall be signed by a LMHP;
2. Be conducted in person in the individual's home or another location of the individual's choice;
3. Document that the individual:
   a. Is between the ages of 15 and 30 at admission;

b. Exhibited psychotic symptoms for less than five years at admission;

c. Has a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum, affective disorder with psychosis, bipolar disorder with psychotic features, major depression with psychotic features, or other psychotic disorder. Individuals may also have a co-occurring diagnosis of a substance use disorder or developmental disability; and

d. Is experiencing symptoms of a mental, behavioral, or emotional illness that results in functional impairments in major life activities. Such symptoms may include auditory or visual hallucinations, delusions, or a thought disorder that causes significant disruptions in at least one of the following areas: (i) educational functioning, (ii) occupational functioning, (iii) relationships with family members, or (iv) building a social support network.

12VAC35-105-1427. Discharge criteria.

Before a CSC provider may discharge an individual, the individual shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the requirements of 12VAC35-105-693. The provider's policy regarding discharge shall require that an individual be discharged when one of the following conditions is met:

1. The individual has successfully completed the CSC program and has transitioned to a lower level of care adequate to support recovery;

2. The individual is unable to achieve the goals of treatment but could progress with a different type of treatment;

3. The individual has achieved the original treatment goals but has developed new treatment challenges that can only be adequately addressed in a different type of treatment; or

4. The individual chooses to be discharged from the program or has not participated in treatment for six months.

12VAC35-105-1428. Service delivery.

A. A CSC program shall meet the following programmatic requirements in accordance with the individual's assessment and ISP.

1. Treatment planning may be developed through a team approach, but the ISP shall be signed and overseen by a LMHP.

2. Psychiatric services to include a comprehensive psychiatric evaluation, medication prescription monitoring, and contact with the individual. The psychiatric evaluation shall be completed as soon as possible but no later than 30 days after admission. Psychiatric services shall be provided by a psychiatrist, psychiatric nurse practitioner, or nurse practitioner or physician assistant working under the supervision of a psychiatrist.

3. Psychotherapy provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.

4. Family education and support provided by any team member acting within the scope of their practice.

5. Health Literacy Support. The medication administration component shall be performed by a RN or LPN. The support component shall be performed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner, occupational therapist, CSAC, CSAC-S, RN, or LPN.

6. CSC rehabilitation skill-building by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, occupational therapist, CSAC, CSAC-S, or registered PRS.

7. Care coordination by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC-S, RN, LPN, or registered PRS.

8. Crisis support provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.

a. Crisis support shall be available 24 hours a day, seven days a week.

b. Crisis support shall not solely include referral to a crisis provider (CRC, CSU, or community-based crisis stabilization, including mobile crisis response) as a means of addressing the crisis.

c. Crisis support shall include the development of the individual's crisis mitigation plan.

9. Peer recovery support services by a registered PRS.

10. Treatment shall be limited to three years of service per treatment episode.

B. A CSC program shall participate in the completion of quality service reviews conducted by DBHDS.

C. A CSC program shall furnish information and documentation on request and in the form requested by DBHDS.

12VAC35-105-1429. Treatment team and staffing.

Each CSC provider shall have sufficient staffing composition to meet the varying needs of individuals

served by the provider as required by this section. CSC services shall be delivered by a multidisciplinary team and the provider shall meet the following minimum position requirements:

1. Team leader who is a designated employee and LMHP with at least three years of experience in the provision of mental health services.

a. The team leader shall be a full-time employee or contractor.

b. The team leader shall oversee all aspects of team operation.

c. The team leader shall routinely provide direct services to individuals in the community.

d. The team leader shall monitor, oversee, and supervise the team-based process.

2. Psychiatric provider who is a designated employee and a psychiatrist, psychiatric nurse practitioner, nurse practitioner with sufficient training and mental health experience, or nurse practitioner or physician assistant working under the supervision of a psychiatrist.

a. The psychiatric provider shall be available to the team to provide assessments and medication management.

b. The psychiatric provider shall serve as fully integrated team member who attends clinical team meetings.

3. An additional clinician who is a LMHP, LMHP-R, LMHP-RP, or LMHP-S. The clinician shall provide psychotherapy.

4. A registered peer recovery support specialist who is a designated employee.

5. Supported employment and education specialist. There shall be one full-time supported employment and education specialist, who shall be a registered QMHP with demonstrated expertise in supported employment and supported education through experience or education.

6. General clinical staff as appropriate to meet the needs of individuals served. Additional staff may include QMHPs, QMHP-Ts, CSACs, CSAC-Ss, occupational therapists, RNs, and LPNs.

7. At least one of the CSC provider team members shall have training working with individuals with substance use disorders.

8. All team members shall complete initial and annual training approved by DBHDS in core and evidence-based practices that support high-fidelity CSC practice. Documentation of completion of initial training shall be provided to the department at the time of application for a full license.

REGULATORY ACTIVITY STATUS REPORT

	VAC CITATION Chapter and Title	SHORT DESCRIPTION	Action Summary	Regulatory Stage	Current Status
PENDING ACTIONS					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CSC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Coordinated Specialty Care (CSC).	**Emergency/ NOIRA**	**PENDING REVISED BOARD ACTION**
UNDER EXECUTIVE BRANCH REVIEW					
Governor's Office					
1	Chapter 115 (12VAC35-115): Regulations to Assure the Rights of Individuals	Updates to Human Rights Regulations; conform to Health Care Decisions Act	Amendments to improve the ability of the Office of Human Rights to protect individuals receiving services; also makes necessary updates to align with Code of Virginia where applicable.	**NOIRA** *April 2025 Board Vote*	SHHR approved 1/8/26
Secretary's Office					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory reporting of previous negative actions by applicants	Pursuant to HB 597 (2020), incorporates statutory requirements for initial provider applicants to report prior disciplinary or other negative actions.	**Fast-Track** *July 2024 Board Vote*	DPB approved 5/5/25 *OAG certified 3/17/25*
2	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory valid discharge plans by substance abuse treatment facilities	Pursuant to HB 434 (2024), incorporates additional statutory requirement for substance use disorder treatment facilities upon discharging an individual from services or when an individual withdraws from a program.	**Fast-Track** *Sept. 2024 Board Vote*	DPB approved 5/2/25 *OAG certified 3/17/25*
Department of Planning and Budget					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CPST	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Community Psychiatric Support and Treatment (CPST).	**Emergency/ NOIRA** *Sept. 2025 Board Vote*	OAG certified 3/23/26
2	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: REC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Recovery and Empowerment Center (REC).	**Emergency/ NOIRA** *Dec. 2025 Board Vote*	OAG certified 3/23/26
3	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Amendments to align with VDH Regulations	Technical and clarifying amendments to reflect current practice and update outdated references.	**Fast-Track** *April 2025 Board Vote*	OAG certified 3/20/26

4	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Technical and clarifying revisions for crisis services	Reduces administrative burden, clarifies provisions, and makes technical amendments to newly implemented crisis services regulations.	**Fast-Track** *July 2025 Board Vote*	OAG certified 3/23/26
5	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 250 (12VAC35-250): Peer Recovery Specialists	Mandatory Peer Recovery Specialist-Trainee (PRS-T) designation	Pursuant to 2024-2026 Appropriation Act, creates a trainee designation to allow individuals to bill for services while working on the 500 hours of experience necessary for full Peer Recovery Specialist certification.	**Emergency/ NOIRA** *Sept. 2025 Board Vote*	OAG certified 3/23/26
Office of Attorney General					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Regulatory Restructuring Seven actions: 1. General Chapter 2. Residential 3. NonCenter-Based 4. Center-Based 5. Crisis Services 6. Case Management 7. Repeal and replace	Appliable provisions of existing licensing regulations are reenacted within a new "umbrella" General Chapter and five service-specific chapters, with corrections, streamlining, and strengthening of regulations where appropriate. (Seventh action repeals current chapters when newly restructured chapters become effective.)	**Proposed** *Dec. 2025 Board Vote*	Submitted to OAG 12/17/25

State Board of Behavioral Health and Developmental Services

Dinner Meeting

DRAFT AGENDA

WEDNESDAY, APRIL 21, 2026

Alta Strada – Mosaic
2911 District Avenue, Fairfax, VA 22031

NO BUSINESS WILL BE CONDUCTED AT THIS MEETING	
1.	**WELCOME AND INTRODUCTIONS**
2.	**DINNER**
3.	**COMMENTS / DISCUSSION**
4.	**CLOSING REMARKS**
5.	**ADJOURNMENT**

DRIVING DIRECTIONS

Archer Hotel Falls Church
8296 Glass Alley
Fairfax, VA 22031
571-327-2277
https://archerhotel.com/falls-church/location

- **Hotel check-in time is 3:00 p.m.**

FROM POINTS SOUTH:

VIA I-95 N

- From I-95 North, take Exit 170B for I-495 North toward Tysons Corner
- Take Exit 50A-50B to merge onto US-50 West/Arlington Boulevard
- Continue on US-50 West/Arlington Boulevard
- Turn right onto Williams Drive
- Turn right onto Eskridge Road
- Turn right onto Glass Alley

FROM POINTS WEST:

VIA I-66 E

- From I-66 East, take Exit 62 toward Nutley Street
- Use the LEFT lane to turn RIGHT onto Nutley Street
- Turn left onto US-29 North
- Turn right onto District Avenue
- Turn right onto Glass Alley

DRIVING DIRECTIONS

Sharon Bulova Center for Community Health
8221 Willow Oaks Corporate Drive, Fairfax, VA 22031
703-559-3000

- Review entry procedures for screening and prohibited items

FROM POINTS SOUTH:

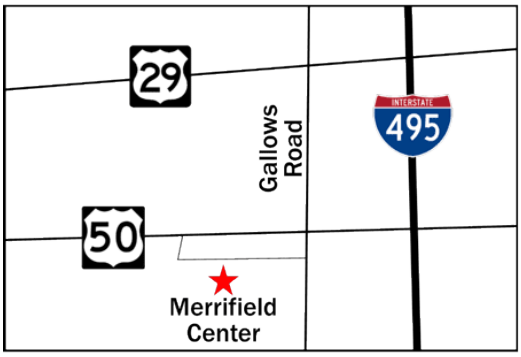
VIA I-95 N

- From I-95 North, take Exit 170B for I-495 North toward Tysons Corner
- Take Exit 50A-50B to merge onto US-50 West/Arlington Boulevard
- Continue on US-50 West/Arlington Boulevard
- Turn left onto Williams Drive
- Turn left onto Willow Oaks Corporate Drive

FROM POINTS WEST:

VIA I-66 E

- From I-66 East, merge onto I-495 South
- Use the second from the right lane to take US-50 West/Arlington Boulevard
- Use the left lane to take the ramp onto US-50 West/Arlington Boulevard
- Turn left onto Williams Drive
- Turn left onto Willow Oaks Corporate Drive



DRIVING DIRECTIONS

DBHDS Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22042

FROM ARCHER HOTEL FALLS CHURCH

Approximately 15 minutes travel time

- Turn left onto District Avenue
- Turn right onto Lee Hwy/US-29 N
- Turn right onto Gallows Road
- Continue on Gallows Road for 1.3 miles
- At light, turn right onto service road at the Blue Entrance to Inova Fairfax Hospital
- Stay on service road (Blue Road) that ends at NVMHI parking lot just past the three-way stop sign.

FROM I-495

- From I-495, take Exit 51 for VA-650/Gallows Road
- Turn left onto Gallows Road at end of ramp
- At light, turn left onto service road at the Blue Entrance to Inova Fairfax Hospital
- Stay on service road (Blue Road) that ends at NVMHI parking lot just past the three-way stop sign.

- **Parking is extremely limited at NVMHI.**
- If you are unable to find a space in the NVMHI lot, park in the **Inova Gray garage**.
- Enter the NVMHI building using the Visitor Entrance.

NVMHI Reception Office
(703) 207-7100

If you have any questions about the information in this meeting packet,
contact Mary Broz Vaughan, mary.broz-vaughan@dbhds.virginia.gov, 804-903-1390.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
3302 Gallows Rd, Falls Church, VA 22042 (703) 207-7100

Please note that some GPS systems have a little issue with our address [3302 Gallows Road, Falls Church, VA 22042] or 3300 Gallows Rd., Falls Church, VA 22042 instead. That will get you to the Inova Fairfax Hospital and share the Blue Entrance service road off Gallows Rd and the main hospital entrance Wellness Blvd off Woodburn Rd. NVMHI is located in back (one-story brick building). You will see signs along the service road indicating the way towards (NVMHI). Follow the service road around to the 3-way stop you will see the Gray Garage as you approach the 3-way stop sign, NVMHI entrance is across the road from the Gray Garage. Due to limited parking at NVMHI if you are unable to find a parking space, we ask that you park in the Inova Gray garage.

Once you enter NVMHI at the stop sign go straight into the small parking lot in front of you. We asks that you enter the building at the **VISITOR ENTRANCE** as indicated above on the map. If you need any assistance please call the receptionist at **703-207-7100** they will transfer your call to the appropriate department. Please inform the receptionist that you are here for a State Board meeting, they will contact Lisa Barnett, Admin for CEO.