



STEP-VA

Performance monitoring and evaluation 2025

Report Document #663

Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

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1 Overview of STEP-VA program

The Behavioral Health Commission (BHC) directed staff to conduct ongoing monitoring and evaluation of the System Transformation Excellence and Performance (STEP-VA) initiative in 2023. Launched in 2017, STEP-VA was intended to expand access to high-quality, publicly funded, essential behavioral health services provided by the state's Community Services Boards (CSBs).

BHC staff used a variety of research methods to evaluate the implementation and performance of STEP-VA, including data analysis, review of program documents and the research literature, interviews, and surveys. BHC staff analyzed data on CSB service utilization, funding, staffing, and performance measures, and reviewed CSB performance contracts, the Code of Virginia, and agency reports. Additionally, staff reviewed relevant documentation including legislative reports, federal guidance on Certified Community Behavioral Health Clinics (CCBHCs), and research literature on behavioral health service delivery models in other states. Interviews were conducted with staff from the Department of Behavioral Health and Developmental Services (DBHDS), CSBs, and other relevant stakeholders. A statewide survey of CSBs was used to gather information on service capacity, barriers to access, and resource needs. (See Appendix A for a detailed description of research methods.)

STEP-VA establishes a set of core behavioral health services required to exist at every Virginia CSB

STEP-VA requires every CSB across Virginia to establish a core set of behavioral health services, ensuring that certain essential services can be accessed statewide regardless of geographic location (Appendix B). STEP-VA was created to address two primary goals: (1) expanding access to behavioral health services across Virginia, and (2) improving the quality of those services.

STEP-VA requires all 40 CSBs to provide nine categories of behavioral health services (STEPS)

STEP-VA standardizes the behavioral health services available across Virginia by requiring all 40 CSBs to provide nine standard service categories (STEPS). The nine STEPs include: (1) same-day access; (2) primary care screening; (3) crisis services; (4) outpatient services; (5) peer and family support services; (6) service members, veterans, and family services (SMVF); (7) psychiatric rehabilitation; (8) care coordination; and (9) case management (Table 1-1).

Table 1-1

CSBs are required to provide nine STEPs through STEP-VA

STEP	Description	Examples of services provided
Same-day access	Timely access to assessments and needed behavioral health services	Initial behavioral health assessments, psychiatric evaluations, screening appointments, triage services
Primary care screening	Primary care screenings and referrals for individuals needing assistance to overcome barriers or accessing primary health services	Physical health screenings, referrals to primary care providers, assistance enrolling in health insurance
Crisis services	Services enabling individuals in crisis to remain in the least restrictive environment, preferably the home or community	24/7 crisis hotlines, mobile crisis response teams, crisis assessment and intervention, crisis stabilization services
Outpatient services	Access to individual or group therapy provided in community within 10 days of assessment	Individual psychotherapy, group therapy, family therapy, , substance use disorder treatment
Peer & family support services	Access to services provided by individuals with lived experience of mental health or substance use and family supports as requested or recommended	Peer support specialists, family support partners, peer-led recovery programs, family support groups
SMVF ¹ services	Support for members of the military & families who are 50+ miles from military treatment (active) or 40+ miles (veterans) to ensure they receive behavioral health services effectively	Military cultural training for staff, specialized counseling for military, coordination with Veterans Affairs services
Psychiatric rehabilitation	Services that help individuals with SMI ¹ , SUD ¹ , and SED ¹ to develop or regain independent living skills	Mental health skills building, supported employment programs, vocational rehabilitation, medication education and self-management
Care coordination	Services that connect individuals to the full range of health, social, and community services they need	Treatment planning, assistance accessing benefits, connection to community resources
Case management	Coordination of behavioral health services to help individuals navigate and access the services they need	Assessment and service planning, assistance during transitions between services

¹SMVF: Service members, veterans, and families services; SMI: serious mental illness; SUD: substance use disorder; SED: serious emotional disturbance

Source: BHC staff analysis of DBHDS STEP-VA manual

The standardization of services across CSBs is designed to ensure that a minimum level of behavioral health services is available statewide. Prior to 2017, CSBs were required to provide only two services: (1) emergency services, which were used primarily to conduct preadmission screenings for individuals under an emergency custody order (ECO), and (2) case management. CSBs could offer additional services at their discretion and based on their fiscal ability, which created significant variation in the availability of services across the Commonwealth. An individual's ability to access behavioral health services depended on where they lived, and the system was oriented toward emergency services rather than consistently including a broader continuum of services to prevent or recover from a crisis.

STEP-VA was implemented progressively between FY18 and FY23

The implementation of the nine STEPs was staggered to allow sufficient time for CSBs to build capacity and for DBHDS to develop performance measures for all STEPs. Implementation began in FY18 with same-day access and concluded in FY23 with the final three STEPs: psychiatric rehabilitation, case management, and care coordination (Exhibit 1-1).

All nine STEPs have been implemented statewide as of FY23. The original implementation timeline required CSBs to provide same-day access and primary care screening by July 1, 2019, with the remaining seven STEPs available by July 1, 2021. However, the General Assembly extended the deadline for the final three services to July 1, 2022, and later delayed implementation until funding was appropriated.

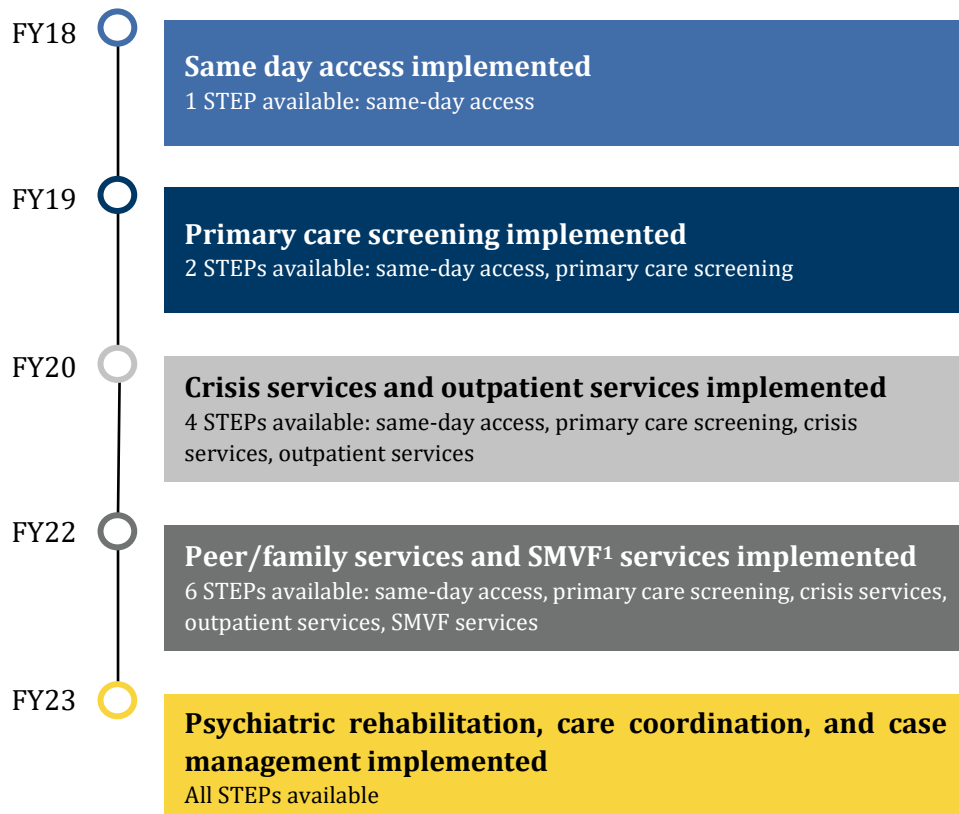
STEP-VA was modeled after the federal Certified Community Behavioral Health Clinic (CCBHC) model

Virginia developed STEP-VA based on the federal CCBHC model, which is a framework of clinics that provide a comprehensive range of behavioral health services with an emphasis on providing 24-hour crisis care, evidence-based practices, care coordination, and integration with physical health care. The state received federal funds in 2015 to plan and develop a statewide CCBHC system. Virginia chose not to officially adopt the entire CCBHC model in 2017 because it was not ready to shift to the different Medicaid funding model associated with CCBHC. Instead, STEP-VA was developed as an alternative approach that adopted CCBHC service requirements while maintaining Virginia's existing Medicaid billing practices.

The CCBHC model establishes six certification criteria that behavioral health providers must meet: (1) staffing standards, (2) availability and accessibility of services, (3) care coordination requirements, (4) scope of services, (5) quality and reporting measures, and (6) organizational authority and governance. CCBHCs are funded through a prospective payment system (PPS) that provides CCBHCs with a fixed daily/monthly amount per individual rather than having to bill for each service provided.

Exhibit 1-1

STEP-VA was implemented progressively between FY18 and FY23



¹SMVF: service members, veterans, and families services

Source: BHC staff analysis of DBHDS annual reports

STEP-VA adopted only the “scope of services” requirement by establishing the same nine categories of services and did not pursue the other five CCBHC certification criteria. Virginia CSBs therefore provide the same range of services as CCBHCs but may operate under different standards for staffing, accessibility, care coordination, quality monitoring, and governance (Table 1-2). Most notably, Virginia does not have a PPS model for financing services.

Four Virginia CSBs currently operate as CCBHCs through federal CCBHC expansion grants: (1) Mount Rogers CSB, (2) New River Valley Community Services, (3) Planning District One Behavioral Health Services, and (4) Richmond Behavioral Health Authority. These CSBs must meet all six CCBHC certification criteria and report performance data to the federal government.

Table 1-2
STEP-VA incorporates some, but not all CCBHC elements

CCBHC certification criteria	STEP-VA requirements	CCBHC requirements
Staffing	CSBs determine staffing based on local needs and available funding	CCBHCs must develop a staffing plan based on a local needs assessment and adhere to specific licensing and training requirements
Availability and accessibility of services	CSBs must make services available, but no specific accessibility standards have been established	CCBHCs accept all patients regardless of ability to pay or residence, and must meet specific response time requirements
Care coordination	CSBs provide care coordination services as one of the nine STEPs	CCBHCs have formal care coordination agreements with other providers, use defined treatment teams, and must meet health information technology requirements
Scope of services	CSBs must provide nine required STEPs: (1) same-day access, (2) primary care screening, (3) crisis services, (4) outpatient services, (5) peer/family support, (6) SMVF ¹ , (7) psychiatric rehabilitation, (8) care coordination, (9) case management	CCBHCs must provide the same nine service categories and must meet person-centered, family-centered, and recovery-oriented care standards
Quality and other reporting	CSBs report data to the state; performance measures and benchmarks are established by DBHDS	CCBHCs report data to the state and to SAMHSA ¹ ; performance measures and benchmarks are established by the state and SAMHSA; CCBHCs must create quality improvement plans
Organizational authority and governance	CSBs operate as local organizations with state oversight through performance contracts	CCBHCs meet state licensing requirements, comply with federal oversight requirements, and include individuals who receive services on their governing boards
Medicaid funding model ²	CSBs receive reimbursement through traditional, per-service rates	CCBHCs receive a fixed amount per encounter per day/month (PPS model)

¹SMVF: service members, veterans, and families services; SAMHSA: Substance Abuse and Mental Health Services Administration

²PPS model is not one of the six CCBHC certification criteria, but is a required component of CCBHC model

Source: BHC staff analysis of STEP-VA and CCBHC requirements

Recommendations from the 2023 BHC review of STEP-VA facilitated some important improvements

The BHC's 2023 report *Monitoring STEP-VA* identified significant gaps in the availability of data and performance measures. BHC members took budgetary action during the 2024 session to address the issues described in the report. Although agency responses generated some improvements in data collection and performance measures, there is still insufficient information to conduct comprehensive monitoring and program evaluation of STEP-VA.

Little information was available to assess the implementation status or performance of STEP-VA in 2023

The BHC's 2023 report found that there was insufficient information available to comprehensively assess the extent to which STEP-VA services can be accessed, or to assess their quality. There was little reference documentation available to ensure a consistent understanding of responsibilities and expectations for STEP-VA among agencies involved in the program, communication between DBHDS and CSBs was not as frequent, and DBHDS did not commonly visit CSBs to get first-hand knowledge of their operations and provide feedback when needed. BHC staff found that:

- Only six of nine required STEPs had been implemented statewide, as the final three STEPs were delayed due to funding issues;
- Access to implemented services was constrained by limited financial and human resources;
- CSBs struggled to maximize Medicaid reimbursement for STEP-VA services;
- Performance measures and benchmarks were finalized for only two of nine STEPs;
- Finalized performance measures were insufficient to assess or hold CSBs accountable for the quality of services; and
- The CSB data system was a barrier to proper data collection and reporting for oversight purposes.

Some progress has been made since 2023

Progress has been made in a number of operational areas since 2023. All nine STEPs are now available in all CSBs, and a large investment has been made to expand the parts of the crisis system that are under STEP-VA (988 call center and mobile crisis response teams). DBHDS has also greatly increased the central office support that is available to CSBs. DBHDS has developed a STEP-VA manual, conducted site visits to most CSBs, hosted weekly STEP-VA office hours, and streamlined some requirements known to create an administrative burden. These efforts have made STEP-VA expectations clearer and have also increased the communication between DBHDS and CSBs. DBHDS's development and transition to a new data system, the Enterprise Data Warehouse (EDW), has also increased clarity and communication by ensuring that DBHDS receives timely and consistent data from CSBs.

BHC members sponsored report recommendations, but implementation sometimes fell short of expectations

The BHC sponsored, and the General Assembly included, eight budget amendments in the 2024 Appropriation Act directing state agencies to examine ways to improve accountability and to obtain the information needed for more robust STEP-VA monitoring (Table 1-3). These recommendations covered the following areas:

- Administrative burden reduction for CSB direct care staff (295 00.2)
- Medicaid billing challenges and technical assistance for CSBs (295 00.4)
- Annual reporting on CSB salaries, turnover, and vacancy rates (295 00.5)
- Needs assessment for all nine STEPs (295 QQ)
- Comprehensive performance contract review and revisions (295 00.3)
- Update of STEP-VA performance measures and benchmarks (295 NN)
- Planning and analysis of barriers to implementing the CCBHC model (267 D)
- Planning for crisis services expansion (267 C.1)

DBHDS and the Secretary of Health and Human Resources released all but one report directed by the BHC as of October 2025. The available reports indicated that since 2023, DBHDS has established additional performance measures and benchmarks for STEP-VA services, including one additional outcome measure. DBHDS has also worked to clarify STEP-VA expectations and provided a comparative analysis between STEP-VA and CCBHC requirements that identified specific gaps and alignment opportunities. Additionally, agency responses often included collaboration with stakeholders through surveys, interviews, and workgroups.

State agency efforts were nonetheless not sufficient to generate the information needed to conduct comprehensive monitoring of the STEP-VA program. Some reports did not provide enough information to support an effective evaluation, provided incomplete data that precluded meaningful analysis, or failed to offer actionable solutions to identified problems. Although DBHDS indicated a needs assessment was conducted, it has not been published. DBHDS has indicated that the needs assessment does not estimate the actual need for STEP-VA services or quantify the resources necessary to meet that need. Additionally, the report on administrative burden does not identify specific areas of burden or offer concrete solutions to reducing administrative burden on CSBs. Similarly, the report on Medicaid billing did not identify specific billing obstacles that CSBs face and the proposed solution was limited to general technical assistance. In the absence of this information, BHC staff relied on surveys and other research methods to prepare this 2025 monitoring report.

Table 1-3

State agencies responded to all but one BHC recommendation

Budget language implementing BHC recommendation (Appropriation Act, Special Session I, 2024)	Report addressing recommendation
Item 295 00.2.	RD378 – Report on the administrative burden on Community Services Boards
Item 295 00.4.	RD922 – Report on Community Service Boards billing for Medicaid eligible services
Item 295 00.5.	RD109 – Annual report on salaries, turnover, and vacancy rates for Community Services Boards
Item 295 QQ.	<i>Not published¹</i>
Item 295 00.3.	RD923 – Community Services Boards performance contracts
Item 295 NN.	RD933 – STEP-VA performance measures and benchmarks
Item 267 D.	RD898 – Report on the implementation of the Certified Community Behavioral Health Clinic (CCBHC) model
Item 267 C.1.	RD517 – Expansion and Modernization of the Comprehensive Crisis Services System

¹As of October 15, 2025

Source: BHC staff analysis of agency reports

Unclear legislative goals have created uncertainty about the future and direction of STEP-VA

The only explicit legislative requirement for STEP-VA is to establish nine core categories of behavioral health services at all CSBs across the state, but the General Assembly has not articulated expectations for the future or direction of STEP-VA once these services are in existence. The 2023 BHC monitoring report recommended creating a legislative vision for STEP-VA, but legislation introduced in the 2024 session to address this recommendation did not pass the General Assembly. In the absence of a cohesive, statewide vision, stakeholders have articulated varying goals and objectives for STEP-VA. This lack of cohesion has created confusion and made it difficult to plan for how to prioritize funding or changes to STEP-VA in the most strategic way.

STEP-VA lacks a clear legislative vision beyond the implementation of core services

Neither Virginia statute nor the Appropriation Act articulate a long-term vision for STEP-VA that would provide direction about the future of STEP-VA, including the level of access that should be offered or the populations that should be served. The only statutory requirement is that the nine core STEPs must *exist* at every CSB. Now that all CSBs offer all STEPs, questions have emerged about what STEP-VA should accomplish moving forward and how success should be measured.

There is currently no benchmark against which to evaluate whether current access to STEP-VA services satisfy legislative intent and whether funding is adequate. Although CSBs are required to provide all nine STEPs, there is no indication of how broadly these services should be available or what level of access would constitute successful implementation. Without clear goals for service delivery, it is also difficult to assess whether differences in the availability of services among CSBs is simply a reflection of difference in community needs, or if funding is not adequately allocated.

In the absence of legislative guidance, DBHDS and individual CSBs have articulated their own goals, which are not always aligned

Establishing clear legislative vision for STEP-VA could help align DBHDS and CSB objectives and improve strategic planning. DBHDS and CSBs have developed their own visions for STEP-VA, which are not always aligned. There are differing views among CSBs and with DBHDS regarding the target population for STEP-VA, the end goal of STEP-VA, and where CCBHC fits into the vision for STEP-VA. DBHDS has articulated several visions that have changed over time, starting in FY18 with a broad implementation vision focused on expanding the number of STEPs available. This vision remained consistent through FY24 as STEPs continued to be implemented. After the implementation of the last three remaining services, DBHDS shifted the stated vision of STEP-VA to focus on “ensur[ing] that Virginians have access to the services they need within their communities to increase and maintain behavioral health stability.” DBHDS has not developed specific goals for “access” or “behavioral health stability,” and there is confusion among CSBs about what DBHDS and the legislature expect in terms of service delivery and performance.

CSBs have also developed their own visions for STEP-VA in the absence of clear guidance from both the legislature and DBHDS. Many CSBs indicated during site visits that their goal is to serve everyone who needs their services, while others reported that their goal is to prepare for CCBHC certification, and still others aim to serve a specific number or proportion of people in their coverage area. Depending upon the vision selected, CSBs may focus on maximizing the number of individuals served with available resources while others prioritize providing more intensive services to fewer individuals. The lack of statewide direction limits the ability of CSBs to develop strategic plans or make informed resource allocation decisions.

OPTION 1

The General Assembly may wish to consider directing the Secretary of Health and Human Resources to convene a taskforce to develop a proposed strategic vision for STEP-VA. The taskforce should at a minimum include representatives from the Department of Behavioral Health and Developmental Services, Community Services Boards, Virginia Association of Community-Based Providers, and the Department of Medical Assistance Services, and should report the proposed strategic vision to the Behavioral Health Commission (BHC) for legislative input by July 1, 2027, with a progress update by November 1, 2026. The Secretary should facilitate a process for incorporating public input into the strategic vision adopted by the BHC and make a final proposal available to the BHC no later than November 1, 2027.

OPTION 2

The General Assembly may wish to consider amending §37.2-500 of the Code of Virginia to codify the strategic vision of STEP-VA during the 2028 session.

2 Funding for STEP-VA

The Virginia General Assembly has made a substantial investment in the STEP-VA program, appropriating over \$690 million since its launch. With this funding, nine core behavioral health service categories (STEPs) have been established across all 40 Community Services Boards (CSBs). CSBs are providing these STEP-VA services to thousands of individuals through millions of annual visits.

Although appropriations to STEP-VA have grown substantially since the program's launch, Department of Behavioral Health and Developmental Services (DBHDS) and CSBs have been unable to direct funds where they are most needed due to the rigid, STEP-specific structure of this funding. Additionally, Medicaid revenue has grown at a slower rate than service costs and other funding sources. This places increasing reliance on state and local funds, which do not leverage federal matching dollars as Medicaid reimbursement does. To address these funding challenges, the General Assembly may wish to (1) provide DBHDS and CSBs with the ability to direct funds where they are most needed, and (2) help CSBs increase their Medicaid revenue.

STEP-VA received dedicated funding totaling more than \$690 million

About \$695 million has been appropriated to the STEP-VA program between fiscal year (FY) 2018 and FY26 (Table 2-1). The initiative has been supported, in part, by dedicated state General Funds, with funds from the American Rescue Plan Act (ARPA) supplementing state dollars in FY22 and FY23. The General Assembly began appropriating funds in FY18 to support planning, preparation, and service provision when same-day access was first implemented.

Funding for STEP-VA has increased from \$5 million in FY18 to \$133 million in FY26. The growth in total funding primarily reflects the staggered implementation of new STEP-VA services. Each time a new STEP was implemented, additional appropriations were provided to support service delivery across all 40 CSBs. The General Assembly appropriated over \$133 million for STEP-VA in FY26, the highest annual funding level since STEP-VA's launch. This increase includes continued funding for all nine STEP-VA services and additional resources for IT infrastructure and cross-service capacity.

Rigid funding structures may not allow DBHDS and CSBs to steer funding toward the greatest needs

Dedicated funds for STEP-VA are appropriated and distributed by individual STEP-VA service. This structure limits DBHDS's and CSBs' ability to adjust and reallocate funds among STEP-VA services, which may be needed to meet community needs. Receiving a single pool of funds would help DBHDS and CSBs to direct funds to the areas of greatest need.

Table 2-1

Over \$690 million has been appropriated to STEP-VA between FY18 and FY26

STEP	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	Total FY18- FY26
Same-day access	\$4.9	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$10.8	\$13.1	\$13.1	\$95.9
Primary care screening	-	3.7	7.4	7.4	7.4	7.4	7.4	9.1	9.1	59.0
Crisis svcs.	-	-	9.8	9.8	31.2	38.4	43.9	40.9	40.9	214.8
Outpatient svcs.	-	-	15.0	15.0	21.9	21.9	21.9	27.9	27.9	151.5
Peer/family support	-	-	-	-	5.3	5.3	5.3	5.8	5.8	27.6
SMVF ¹	-	-	-	-	3.8	3.8	3.8	4.2	4.2	20.0
Psychiatric rehab.	-	-	-	-	-	2.2	3.8	4.0	4.0	14.0
Care coordination	-	-	-	-	-	6.5	6.5	6.8	6.8	26.7
Case management	-	-	-	-	-	3.2	4.1	4.2	4.3	15.8
<i>Cross-step admin</i>	-	-	-	-	4.9	11.0	11.9	11.9	11.9	51.6
<i>IT infrastructure</i>	-	-	-	-	-	2.6	5.2	5.2	5.2	18.2
Total	\$4.9	\$14.5	\$43.0	\$43.0	\$85.4	\$113.2	\$124.7	\$133.1	\$133.1	\$695.0

¹SMVF: service members, veterans, and families services

Source: BHC staff analysis of Appropriation Acts spanning FY18-FY26

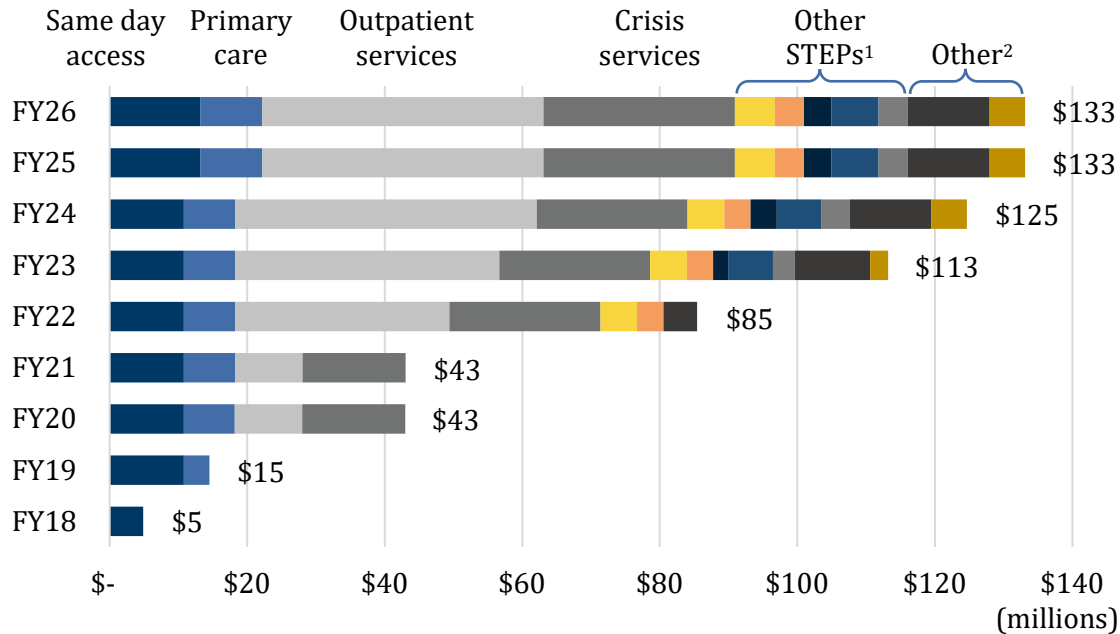
STEP-VA funding is appropriated by STEP and has remained relatively stable over time for most STEPs

The General Assembly specifies in the Appropriation Act how much funding is provided for each STEP; therefore, the allocation of these funds among Virginia's 40 CSBs must be made by STEP as well. The amount appropriated for most STEPs has remained relatively steady since their initial rollout, with only modest increases to account for inflation (Figure 2-1). This approach has provided DBHDS and CSBs with predictable revenue streams for most STEPs, but it has also limited their ability to expand specific STEPs or redirect funds during implementation. Funding for crisis and outpatient services are the exception. The General Assembly has made significant investments to expand the capacity of the crisis STEP as part of its efforts to build a more robust crisis system across Virginia. STEP-VA crisis services funding increased from \$9.8 million in FY20 to \$40.9 million in FY26. Outpatient services

funding increased from \$15 million in FY20 to \$27.9 million in FY26, largely to address workforce challenges that were exacerbated during the COVID-19 pandemic.

Figure 2-1

Appropriations for each STEP have remained relatively steady, other than for outpatient and crisis services



¹Other STEP1: case management; care coordination; psychiatric rehab; service member, veterans, and families services; peer and family services

²Other: cross-STEP capacity; IT infrastructure

Source: BHC staff analysis of Appropriations Acts spanning FY18-FY26

DBHDS provides CSBs with an allocation of STEP-VA funds that is broken out by STEP, using two allocation approaches (Table 2-2):

- A formula for six services (primary care screening, outpatient, crisis, SMVF, peers, care coordination).
- An equal division across CSBs for the remaining three services (same-day access, psychiatric rehab, and case management) through FY25.

DBHDS developed allocation formulas that consider multiple economic and social factors within each CSB coverage area, such as population in poverty; Asset Limited, Income Constrained, Employed (ALICE) scores; Behavioral Health Index (BHI) scores; uninsured population; and rurality. While the factors used in the formula are generally known, the formulas themselves are not available. They were developed and applied to the amount appropriated by the General Assembly for each STEP as it was rolled out, and appear to have not been updated or re-evaluated since then. When the General Assembly appropriated more funding to a STEP, the increase was divided equally between the CSBs and added to their initial allocation, with the exception of crisis and outpatient services funding.

DBHDS has designed funding formulas for the three services that were allocated by equal division and applied the formula to FY26 allocations. The re-allocation of funds between CSBs was offset using federal block grant money; therefore, CSBs received the same amount of funding for these STEPs in FY26 as they did under the equal division allocation method. DBHDS is planning to apply a standardized funding formula to all STEPs in FY28 and is considering factors such as population size, adult and child uninsured rates, disability rates, wellbeing scores, ALICE scores, and serious mental illness/substance use disorder/serious emotional disturbance claim percentiles in the funding formula.

Table 2-2

Funding for STEPs is distributed to CSBs through two allocation methods (FY17-FY25)

STEP	Total appropriated	DBHDS allocation method	Amount allocated per CSB (range)
Same day access	\$11,964,975	Equal division ¹	\$299,124
Primary care screening	\$8,245,865	Formula	\$45,794 - \$503,142
Outpatient svcs	\$24,299,623	Formula	\$404,249 - \$1,223,870
Crisis svcs	\$26,954,924	Formula	\$0 – \$6,253,878 ²
Peer & family svcs	\$5,133,879	Formula	\$92,000 – \$321,185
Service members, veterans, & family svcs	\$3,840,490	Formula	\$0 – \$273,363
Psychiatric rehab	\$3,820,000	Equal division ¹	\$95,500
Case management	\$6,514,138	Formula	\$90,000 – \$284,201
Care coordination	\$4,078,480	Equal division ¹	\$101,962

¹DBHDS developed new formulas for same day access (SDA), psychiatric rehab, and care coordination in FY25. Differences in funding resulting from the new allocation methodology were offset using federal block grant money to hold each CSB harmless in FY26.

²STEP-VA crisis funds are appropriated only to the CSBs that act as the regional crisis hub

Source: BHC staff analysis of DBHDS funding data

DBHDS and CSBs lack flexibility to re-allocate and steer funds to areas of greatest need

DBHDS and CSBs report that allocating funding by STEP limits their ability to reallocate funds in order to direct resources to the areas of greatest need. DBHDS cannot redistribute funds across STEPs to reflect insights provided by performance data or to respond to CSB requests. Setting out funding levels for each STEP was appropriate during STEP-VA's implementation, when STEPs were rolled out at different times. Now that all STEPs have been implemented, funding allocations do not always align with actual service needs or costs. For example, DBHDS reports that some STEPs receive allocations that are below the actual cost of

providing services, and the flexibility to reallocate funding would be helpful in addressing these gaps.

Similarly, performance contracts prohibit CSBs from using the funding designated for one STEP to support another STEP. CSBs report that these restrictions prevent them from being able to respond to changing community needs, address capacity gaps, and optimize resources. For example, some CSBs report receiving excess funding for certain STEPs while not receiving enough for others. The ability to move funding to STEPs with insufficient capacity could help them better serve their communities. Performance contracts should continue to require CSBs to offer all nine STEP-VA services in order to maintain a full continuum of care, even if funding becomes more flexible.

RECOMMENDATION 1

The General Assembly may wish to consider appropriating STEP-VA funding as one amount rather than setting out appropriations for each STEP, beginning with the 2026-2028 Appropriation Act.

RECOMMENDATION 2

The Department of Behavioral Health and Developmental Services should make necessary changes to the Community Services Board performance contract to eliminate STEP-specific distribution of funds.

Medicaid funding has not kept pace with the rising cost of STEP-VA services nor with other funding sources

STEP-VA dedicated funding is not intended to cover the entire cost of providing services through the program. CSBs are supported by additional funding streams expected to absorb the majority of STEP-VA costs, including local government funds, other state general funds, and, particularly, Medicaid reimbursements. Although Medicaid revenues cover a large portion of the cost to provide STEP-VA services, Medicaid revenue has not increased at the same pace as program costs or other funding streams. CSBs are consequently becoming more reliant on the state and localities for support, rather than maximizing federal funds. CSBs report that this slow growth in Medicaid revenue is in part attributable to complex billing processes, high denial rates, and low reimbursement rates for Medicaid services. Identifying and reducing some of these barriers to billing may increase Medicaid revenue for CSBs.

Average cost of a CSB visit has increased since FY17

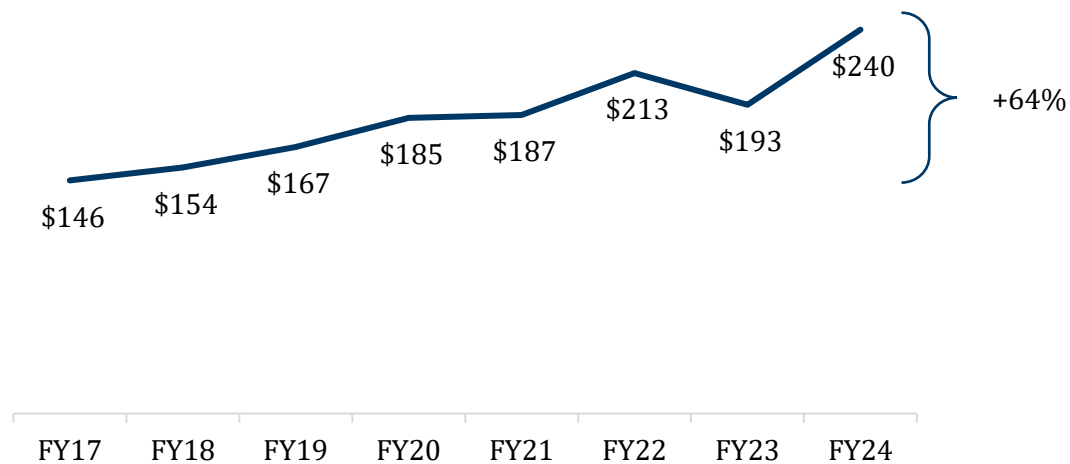
On average, it cost CSBs \$240 to provide services during one visit in FY24, representing a \$94 increase since FY17 based on an analysis of CSB costs and revenues (Figure 2-2). This increase is partly attributable to the broader array of services available through STEP-VA. However, CSBs report that the increase in cost per visit has been driven largely by rising personnel costs and sustained inflation.

Personnel is the largest component of CSB expenditures, and workforce shortages have led to increasing salaries and higher costs per visit according to CSB staff interviewed for this study. CSBs face substantial competition from the private sector, which often entices behavioral health professionals with higher salaries and fewer administrative duties. Potential new hires are requesting higher wages than in previous years, and sometimes receive retention incentives, bonuses, and salary increases. A few CSBs also reported that their locality has mandated salary increases that are not fully covered by local funds and must be absorbed by other funding sources.

Increased operational costs were cited as an additional driver of higher costs per visit. The cost of necessary materials for services and facility costs have increased over time due to high inflation rates. CSBs also report that the costs associated with administrative and documentation requirements have increased, meaning that each visit requires more staff time and resources. Lastly, additional expectations and stricter staffing requirements have impacted the cost of certain STEPs as the program has moved toward Certified Community Behavioral Health Clinic (CCBHC) certification, as described in the previous section.

Figure 2-2

Average cost of a CSB visit increased by 64 percent (\$96) between FY17 and FY24

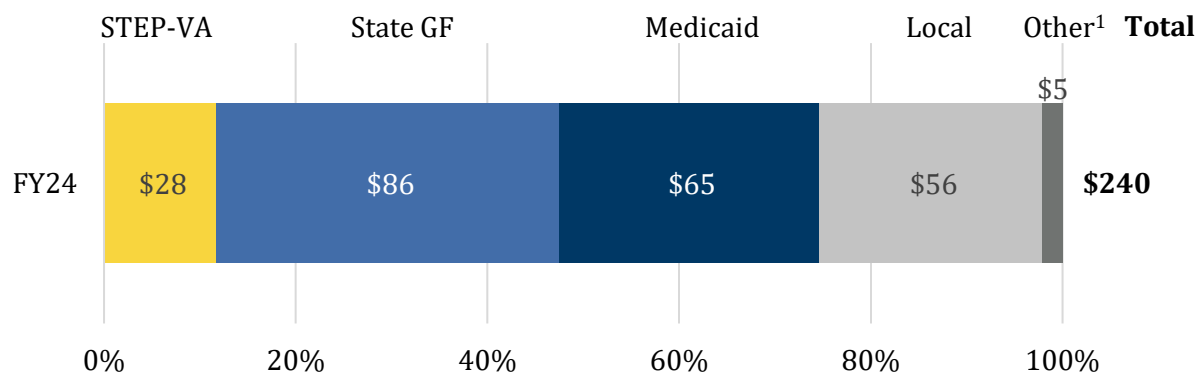


Source: BHC staff analysis of CSB financial data submissions (FY17-FY24)

STEP-VA dedicated funds account for about 15 percent of CSB revenue

STEP-VA dedicated funds are only one of several funding streams supporting the provision of STEP-VA services. A variety of funding sources also help to cover costs, including state general funds not tied to STEP-VA, Medicaid, local government funds, and other grants. In FY24, Medicaid revenue and state general funds covered the majority of the cost of a visit, while STEP-VA dedicated funds covered approximately 15 percent (\$28) of the cost of a visit (Figure 2-3).

Figure 2-3
STEP-VA funding covered 15 percent (\$28) of the cost of a visit in FY24



¹Other: may include grants and other CSB-specific funding sources

Source: BHC staff analysis of CSB financial data submissions (FY17-FY24)

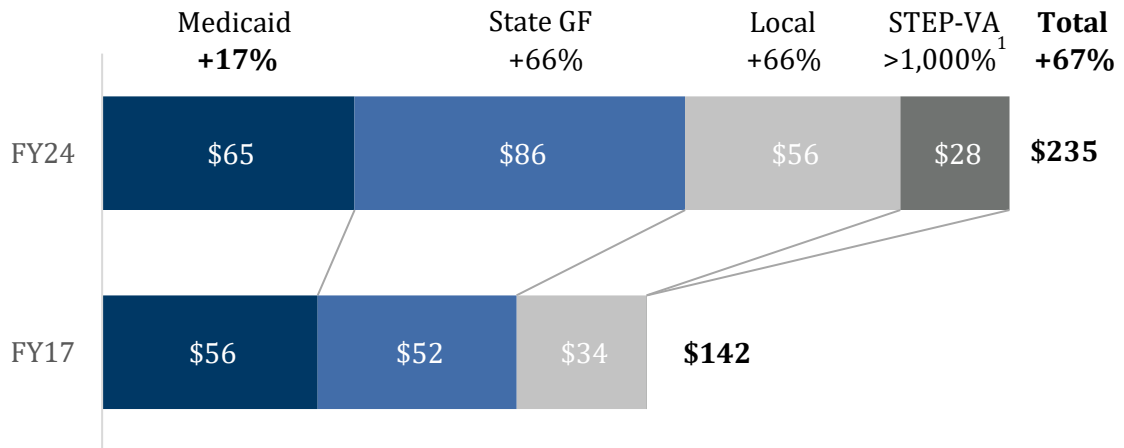
Medicaid revenue increases have not been commensurate with rising costs per visit

Medicaid revenue has not kept pace with the increase in the average cost of a CSB visit. Between FY17 and FY24, Medicaid revenue per visit increased by about 17 percent (Figure 2-4), while the average cost per CSB visit increased by 64 percent. In contrast, local government funding and state general funds both increased by about 66 percent during the same time period. STEP-VA funding also increased from \$0 in FY18, when the program was launched, to about \$28 per visit as STEPs were rolled out and implemented statewide. Medicaid is generally preferable to other funding streams because the state receives a significant federal match for every dollar spent to treat Medicaid patients. Therefore, when general funds or local funds are used instead of Medicaid, the state and localities must pay 100 percent of the cost of services.

CSBs report facing significant obstacles to submitting and collecting Medicaid reimbursements. Since 2018, CSBs have had to work with six different managed care organizations (MCOs), each with different billing methods, credentialing requirements, and authorization processes. Nearly 90 percent of CSB executive directors indicated that their CSB's administrative workload had "increased substantially" because of the shift to managed care, according to a 2022 Joint Legislative Audit and Review Commission (JLARC) report. Furthermore, CSBs report duplicative training requirements, delays in provider credentialing, frequent changes to billing systems, and a rising denial rate for reimbursement since the MCO system was established. JLARC found that billing issues, denials, and credentialing problems have prevented some CSBs from collecting Medicaid funds. For example, two separate CSBs were unable to collect \$700,000 and \$1 million annually. When CSBs do bill Medicaid, they report frequently receiving low reimbursement rates. Medicaid

rates for behavioral health services often do not cover the full cost of providing services and most have not increased to match the rising costs of services.

Figure 2-4
Medicaid revenue per visit has not increased at the rate of other STEP-VA funding sources



¹STEP-VA funding was phased in between FY18 and FY23

Source: BHC staff analysis of CSB financial data submissions (FY17-FY24)

The state has recognized some of these challenges and is working to address them through Behavioral Health Redesign, which entails new rates intended to support evidence-based service delivery. However, these reforms will take time to develop and implement. In the interim, CSBs are not maximizing Medicaid dollars to provide STEP-VA services. Identifying the specific areas that create administrative complexity and using data to estimate their impact on Medicaid revenue could increase Medicaid revenue for CSBs; this information could be used to help make a more compelling case to MCOs that changes are needed, reduce barriers to billing, and lower denial rates.

OPTION 3

The General Assembly may wish to consider directing the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Department of Medical Assistance Services (DMAS), to assist a representative sample of Community Services Boards (CSBs) with conducting an analysis of their Medicaid revenue. This analysis should examine enrollment in Medicaid compared to eligibility, MCO denial rates; time spent on billing, Medicaid losses experienced on STEP-VA services, and collections from patients, as well as the primary factors driving results from the analysis. DBHDS and DMAS should work with CSBs to create an action plan that identifies the changes needed to maximize Medicaid revenue, how changes will be implemented, and on what timeline. The action plan should be completed and communicated to the Behavioral Health Commission by December 1, 2026.

Virginia has been moving toward CCBHC requirements and quality, but without a financing mechanism

CSBs have been expected to provide higher-quality services that align with CCBHC program requirements, but they have received no additional funding to mitigate the costs of complying with these higher standards. Since FY22, DBHDS has included in performance contracts a growing number of requirements that align with CCBHC standards, such as offering certain evidence-based services (Table 2-3). Likewise, the majority of STEP-VA performance measures now reflect CCBHC program requirements. The STEP-VA Advisory Committee (STAC)—which is composed of DBHDS leadership, subject matter experts, and CSB executive directors—adopted CCBHC certification as a program goal.

CCBHC program requirements align with best practices and have been adopted as part of Virginia's effort to increase the quality of STEP-VA services; however, these new requirements result in additional compliance costs for CSBs. For example, CSBs may have to purchase proprietary materials to implement certain evidence-based practices, hire additional licensed staff to meet qualification requirements, provide additional training, or adjust workflows and electronic health records. While additional requirements have been placed on STEP-VA services, the funding for each STEP has not been adjusted to reflect the expanded scope, the new requirements, and the quality of services that CSBs are now expected to provide.

Many CSBs report that STEP-VA funding levels do not align with the new expectations that have been established, yet they believe they are expected to serve the same number of people while meeting significantly higher quality and operational standards. When existing funding is not sufficient to cover both the demand for services and the new quality requirements, they may have to reduce the number of people they serve to comply with quality standards.

Virginia has not adopted a prospective payment system (PPS), which could mitigate compliance costs

A distinguishing feature of the CCBHC model is its reimbursement process, named the prospective payment system (PPS). The PPS model reimburses providers at a fixed rate for each patient served, regardless of the specific services delivered. In contrast, Medicaid providers in Virginia are reimbursed a certain amount for each service provided. The PPS approach is designed to cover the comprehensive array of high-quality services and to provide more stable, predictable funding for providers.

Reimbursement rates under the PPS model tend to be higher than under the traditional Medicaid model, because they account for the full scope of delivering health services, including expenses related to meeting CCBHC certification requirements and compliance costs. States that implement PPS as part of their CCBHC program also receive an enhanced federal matching rate, which increases the federal share of Medicaid reimbursement.

Table 2-3

Additional CCBHC requirements have been added to the FY26 performance contract between DBHDS and CSBs

STEP	Additional requirements in FY26 performance contract
Same day access	- Expanded assessment options - Assessment completed by licensed professionals or those eligible for licensure
Primary care screening	No additional requirements
Crisis services	- Develop processes to work with private providers to provide crisis services - Monitor provider performance and submit quarterly reports to DBHDS
Outpatient services	- Offer 4 EBPs¹: Cognitive Behavioral Therapy, Motivational Interviewing, Medication Management, and long-acting injectable psychotropic medications - Offer at least one additional EBP from approved list
Peer & family support services	- Expand role of Peer Recovery Specialists and Family Support Partners - Provide DBHDS training every three years
SMVF ¹	May develop regional SMVF program aligned with DBHDS requirements
Psychiatric rehabilitation	20 additional services allowed <i>Supported employment will be required in future years</i>
Care coordination	- Track participation in referred services - Document reasonable attempts to determine medication provided by other providers - Aid in accessing benefits and enrolling in programs or supports
Case management	No additional requirements

¹EBP: evidence-based practice; SMVF: service members, veterans, and families services

Source: BHC staff analysis of CSB performance contracts (FY 2023 – FY 2026)

Virginia considered adopting the PPS model when it first explored CCBHC certification in 2017. Transitioning to a new reimbursement model would have required additional state funding in the near term, which could not be absorbed into the budget due to Virginia's fiscal situation in that year. CCBHC certification was examined a second time in 2022, but DMAS was unable to make the significant changes to Virginia's Medicaid structure and MCO

contracts that would have been necessary to adopt PPS in light of other priorities, such as Medicaid expansion, unwinding, and Project BRAVO.

OPTION 4

The General Assembly may wish to consider directing the Department of Medical Assistance Services (DMAS) to (i) identify the steps necessary for Virginia to effectively and efficiently transition to a prospective payment system (PPS) as required to fully adopt the CCBHC model, and (ii) estimate any fiscal impact to the state and to Community Services Boards (CSBs), and (iii) report findings to the House Appropriations Committee, the Senate Finance and Appropriations Committee, and the Behavioral Health Commission by December 1, 2026.

As part of this report, DMAS should estimate a timeframe for transitioning to PPS and examine the actions needed with respect to rate-setting; approval process from the Centers for Medicare and Medicaid Services; managed care organization contract modifications; electronic health records and billing system updates; and any other necessary changes. DMAS should also identify ways to reduce the billing and reimbursement challenges that have been experienced by CSBs under the current Medicaid model.

3 Access to STEP-VA services

One of the primary goals of the STEP-VA program has been to enhance statewide access to a set of core behavioral health services (STEPS) through Virginia's Community Services Boards (CSBs). Prior to the program launch in 2017, CSBs were required to provide only two services: (1) emergency services, and (2) case management. The ability to receive other behavioral health services, such as counseling or crisis stabilization services, varied widely based on geographic location and a CSB's fiscal ability. Today, the nine required STEPs are available in every CSB across the state, as envisioned in statute. However, their availability varies depending on each CSB's need for specific services, the resources that have been made available to CSBs to provide these services, and the extent to which services already existed at CSBs prior to STEP-VA.

STEP-VA appears to have expanded the availability of behavioral health services across Virginia, yet some barriers continue to limit access to these services. STEP-VA services are available in nearly all localities, but transportation challenges and staffing shortages may prevent individuals from receiving STEP-VA services when and where they need them. Furthermore, it remains unclear to what extent STEP-VA has improved access and is meeting community needs for behavioral health services because comprehensive needs assessments have not been conducted. Without baseline data on community needs, it is difficult to determine whether current service levels are sufficient to meet demand for STEP-VA services.

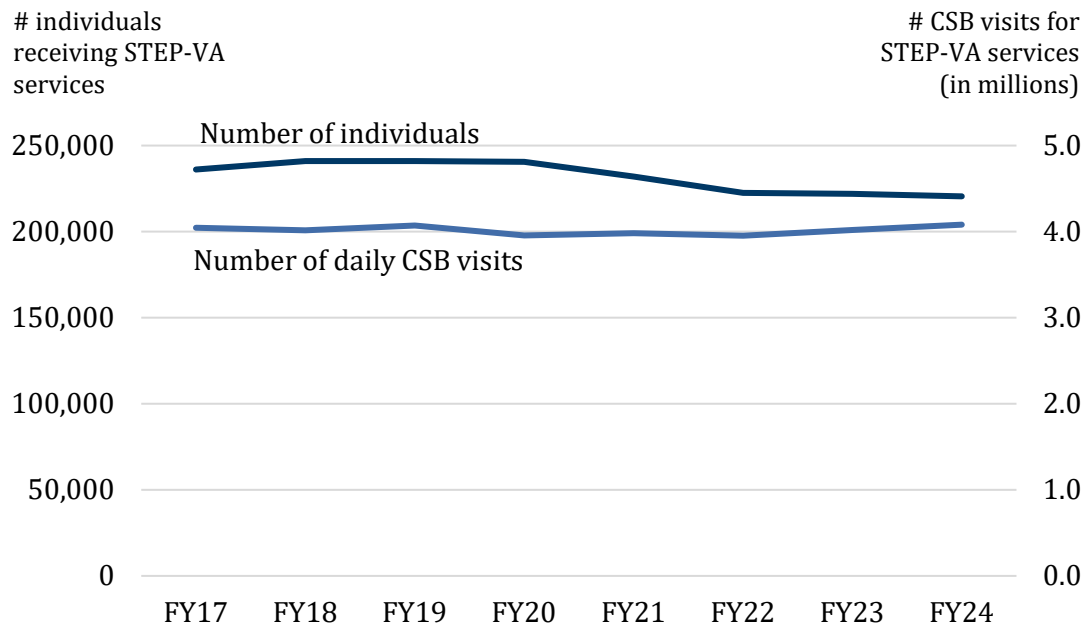
STEP-VA is providing services to thousands of individuals

Thirty-six CSBs provided STEP-VA services to about 204,000 individuals in fiscal year (FY) 2024, about the same number served in FY17, based on an analysis of CSBs records provided to BHC staff. The total number of CSB visits has also remained relatively stable throughout the implementation period for STEP-VA. Individuals in need of services collectively made between 4.4 and 4.7 million visits to CSBs statewide each year (Figure 3-1). CSBs are likely providing more services per visit than before STEP-VA implementation. CSBs report that individuals often receive multiple types of services during a single visit.

Most individuals received mental health services during their visits to CSBs, based on the service categories available in CSBs' financial systems (Figure 3-2). These services include most STEPs, with the exception of same day access (SDA) assessments that are reported individually in a separate category. There were fewer visits for substance use disorder (SUD) services; however, CSB staff indicated that they likely provide more SUD services than are reflected in the data. CSB staff must select a single primary diagnosis for each client in their data system, even when the individual has co-occurring mental health and substance use disorders. Most CSB clients have co-occurring disorders, and CSB staff tend to choose the mental health diagnosis as the primary diagnosis even when some of the services they provide during a visit are related to substance use disorders.

Figure 3-1

Number of individuals served by CSBs and visits made has remained relatively stable during implementation of STEP-VA

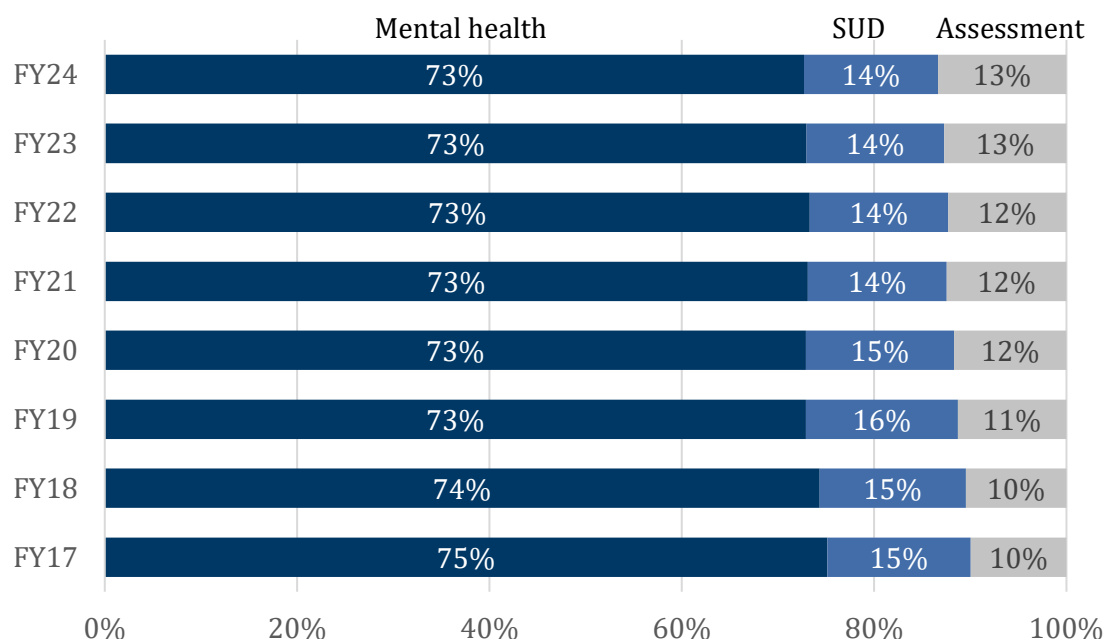


Source: BHC staff analysis of data submissions from 36 CSBs (FY17-FY24)

All CSBs now provide STEP-VA services, but availability and accessibility still vary among CSBs

All nine STEPs have been implemented in every CSB across Virginia, with the final three STEPs, (1) psychiatric rehabilitation, (2) care coordination, and (3) case management, implemented in FY24. Despite statewide implementation, the availability of and access to specific services still varies between CSBs. Virginians can access all STEPs somewhere within their CSB's coverage area, but services may be available in another locality or far from their location within one locality. The specific services offered within each STEP also vary by location, and residents may still be unable to access the exact services they need at their local CSB. Furthermore, staffing and transportation barriers have limited CSBs' ability to expand access to STEP-VA services.

Figure 3-2
Most individuals receive mental health services during CSB visits



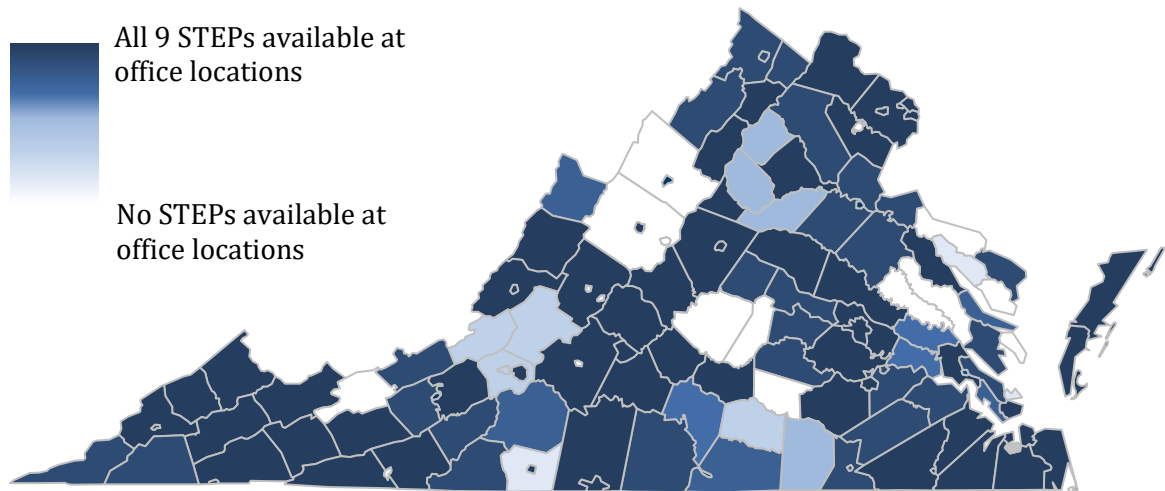
Note: Mental health services include crisis stabilization, mental health outpatient services, psychiatric rehabilitation, primary care screenings, peer services, case management, care coordination, SMVF services. SUD services include substance use outpatient services, peer services, case management, care coordination, SMVF services. Assessment services include SDA assessments, SMVF services
 Source: BHC staff analysis of data submissions from 36 CSBs (FY17-FY24)

STEP-VA services are available in all CSB coverage areas and at office locations in nearly all localities

All STEPs are available in every CSB coverage area and appointments are available at office locations in nearly every locality in Virginia (Exhibit 3-1). Most localities have at least one physical office location that offers at least one STEP, and many are able to provide all STEPs at offices within their locality. There is variation among CSBs, however. Localities in the Shenandoah Valley and those surrounding the Northern Neck are less likely to have physical office locations where STEP-VA services can be provided. In these areas, residents may need to travel to neighboring localities to access STEP-VA services, or CSBs may be able to provide services through other delivery methods, such as telehealth or mobile services. These methods can help expand the reach of CSBs beyond what is available in physical offices and can be particularly useful in less-populated areas, where the demand for services is not large enough to warrant multiple office locations.

Exhibit 3-1

At least one STEP is available in majority of localities



Source: BHC staff analysis of 2025 survey of CSBs (39 of 40 responding)

Same day access and psychiatric rehabilitation are the two STEPs that are available in the fewest localities (See Appendix C for more detailed information on access and quality for each STEP). The more limited availability of same-day access locations can create barriers for individuals seeking behavioral health services. When same-day access is not available locally, individuals may delay seeking care, travel long distances to reach services, or resort to emergency departments. In contrast, psychiatric rehabilitation may not require physical locations in every locality to be effective. These services may be more effectively delivered at centralized facilities that can serve individuals from multiple localities, because fewer individuals require this intensive level of care, and more specialized resources and staffing are needed.

Implementation of all STEPs does not guarantee uniform access to the same type or level of care

Although every CSB offers the same nine STEPs, they do not provide uniform access to the same level or type of care across Virginia. STEPs represent broad categories of behavioral health services, rather than specific, standardized interventions or services.

The specific services offered within each STEP and the capacity of specific services available in each locality may vary widely between CSBs. For example, CSBs may offer:

- more and/or different types of evidence-based practices;
- different levels of crisis interventions (i.e., crisis receiving center (CRC), crisis stabilization unit (CSU), mobile crisis); or
- in-house primary care screenings while others may offer referral services.

Some individuals may therefore need to travel significant distances to access the specific intervention or service they need within a broader STEP. The availability and accessibility of

specific services at each CSB is unknown because that level of detailed data is generally not collected or reported. The availability of services appears to depend, in part, on the extents to which resources have been made available to CSBs; specific services are needed in their area; and specific services already existed prior to STEP-VA. CSBs with greater state and local funding and more Medicaid revenue may have been able to implement a broader array of services within each STEP.

There is also variation among CSBs on other factors that impact access to services, including the availability of appointments, the size of wait lists to access services that are offered, and the hours when office locations are open.

Transportation and staffing barriers hinder access to STEPs in the majority of CSBs

Lack of transportation is the greatest barrier to individuals accessing STEP-VA services when they are needed, according to two-thirds of respondents to a June 2025 BHC staff survey of CSBs (Appendix A). CSBs in rural areas ranked transportation as an especially significant barrier, because their service locations tend to be further apart and there are limited public transportation options. These challenges make it more difficult for individuals to access STEP-VA services even when they are offered.

Nearly two-thirds of survey respondents (64 percent) reported that inadequate staffing is another significant barrier that can prevent individuals from accessing STEP-VA services. Inadequate staffing can prevent CSBs from serving all individuals who need services in a timely manner, expanding service hours, or offering services in multiple locations.

CSBs attributed inadequate staffing to difficulties recruiting qualified staff and the inability to offer competitive salaries. Specialized positions, such as psychiatrists, licensed clinical social workers, and registered nurses, were cited as the most challenging to fill. The reasons behind recruiting difficulties vary among CSBs; rural CSBs face a shortage of behavioral health professionals in their area and have difficulty recruiting qualified staff to relocate. The highest average vacancy rates in rural CSBs were for nursing staff (26 percent), direct services providers (21 percent), clinicians (20 percent), and peer staff (22 percent) during the fourth quarter (Q4) of FY25. Urban CSBs have a larger pool of behavioral health professionals in their area, but they have difficulty offering attractive salary packages due to competition from private providers. The highest average vacancy rates in urban CSBs were for peer staff (24 percent), case management staff (16 percent), clinicians (14 percent), and direct services providers (14 percent) in Q4 of FY25.

Even when CSBs are able to recruit qualified behavioral health professionals, they often experience high turnover rates that compound staffing challenges. CSBs had an average turnover rate of 19 percent with the highest turnover rate among peer staff (32 percent), direct service providers (27 percent), nursing staff (25 percent), and case management staff (19 percent) in Q4 of FY25. The administrative burden faced by CSB staff reportedly contributes significantly to these high turnover rates. Staff frequently cite paperwork, assessment, and data reporting requirements specific to CSBs as reasons for leaving, according to the BHC staff 2025 survey and interviews with CSBs.

Extent to which STEP-VA meets community behavioral health needs is largely unknown

The STEP-VA program and dedicated funding have increased the number and types of services available at CSBs, but it is still unclear to what extent STEP-VA services are meeting the behavioral health needs of communities. Only four CSBs have conducted comprehensive needs assessments, and the state's attempt to conduct a needs assessment in 2024 did not provide reliable information to address this question. This gap in information limits the state's ability to determine whether funding is being allocated to the STEPs and CSBs with the greatest unmet need. Additionally, without baseline measurements of community need, it is impossible to assess whether STEP-VA is effectively reducing gaps in behavioral health care or the extent to which current funding levels and allocations are improving access to services.

Virginia lacks robust assessment of need for STEP-VA services

Despite knowing that there is significant variation in service delivery capacity and population needs among CSBs, Virginia has not systematically measured the actual demand for STEP-VA services, identified underserved populations, or analyzed geographic disparities in service accessibility. The absence of a robust assessment of need for STEP-VA services prevents understanding the true extent of unmet need for behavioral health services and limits its ability to make informed decisions on funding priorities for STEP-VA.

The Certified Community Behavioral Health Clinic (CCBHC) model requires comprehensive community needs assessments as a foundation for service planning and delivery. The assessments must examine the prevalence of mental health and substance use conditions, economic and social determinants affecting access to services, and systematic identification of underserved populations. Four CSBs currently operate as CCBHCs (Mount Rogers, New River Valley, Planning District One, and Richmond) and have conducted these robust needs assessments as required for federal certification. These assessments enable CCBHCs to align their staffing plans, service offerings, and outreach efforts with documented community needs. The remaining 36 CSBs operate without comparable assessments and may rely on less systematic approaches, such as wait list data, to estimate behavioral health needs.

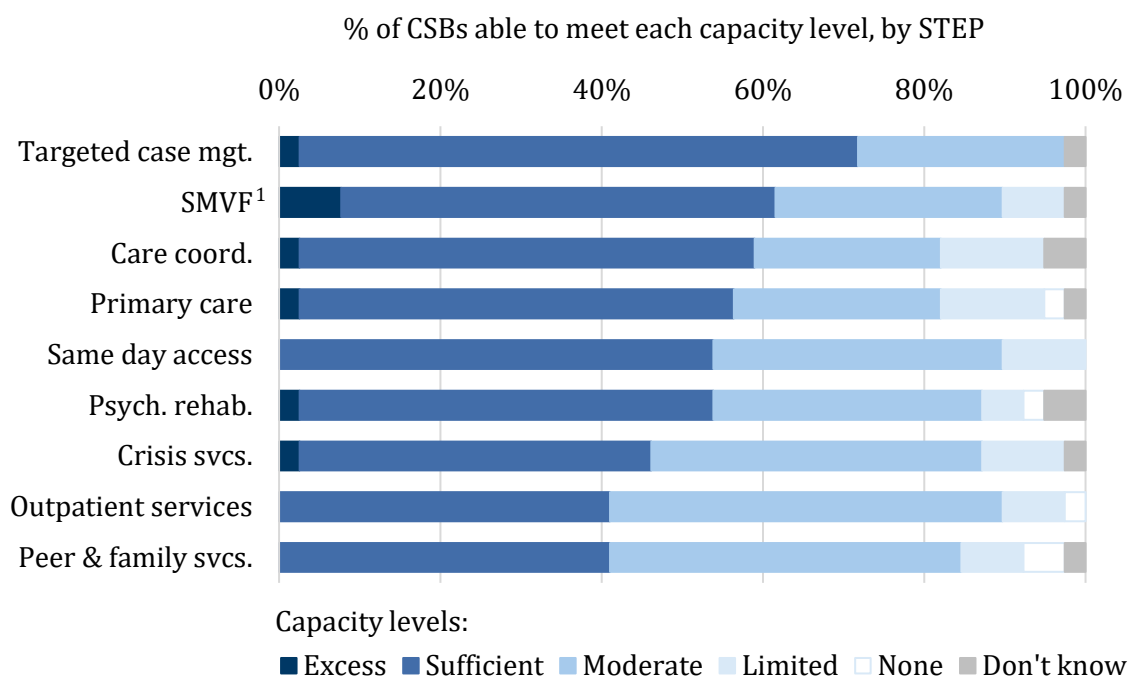
Most CSBs estimate being able to meet the majority of the need for STEP-VA services in their community, *with important caveats*

The majority of CSBs report having sufficient or moderate capacity to meet community needs across all STEPs, based on estimates provided through a BHC staff survey of CSBs (Figure 3-3). CSBs' ability to meet community needs is highest for case management and care coordination. CSBs may have greater capacity for these STEPs because they often already existed prior to STEP-VA implementation, and CSBs were able to build upon existing infrastructure to maximize the capacity of these STEPs.

In contrast, CSBs report a more limited capacity to meet the needs for outpatient services, crisis services, and peer and family services. CSB staff have reported that outpatient services and peer and family services are underfunded and that they are not able to provide enough of these services to meet the needs of their community. Challenges with CSBs' ability to

provide outpatient services may also contribute to more demand for crisis services; preventative interventions, which are offered within the “outpatient services” STEP, may help individuals manage their behavioral health conditions so they do not escalate and reach crisis level, and follow-up care offered after a crisis can help prevent recurrence.

Figure 3-3
Most CSBs are able to meet community needs across all STEPs, but with variation



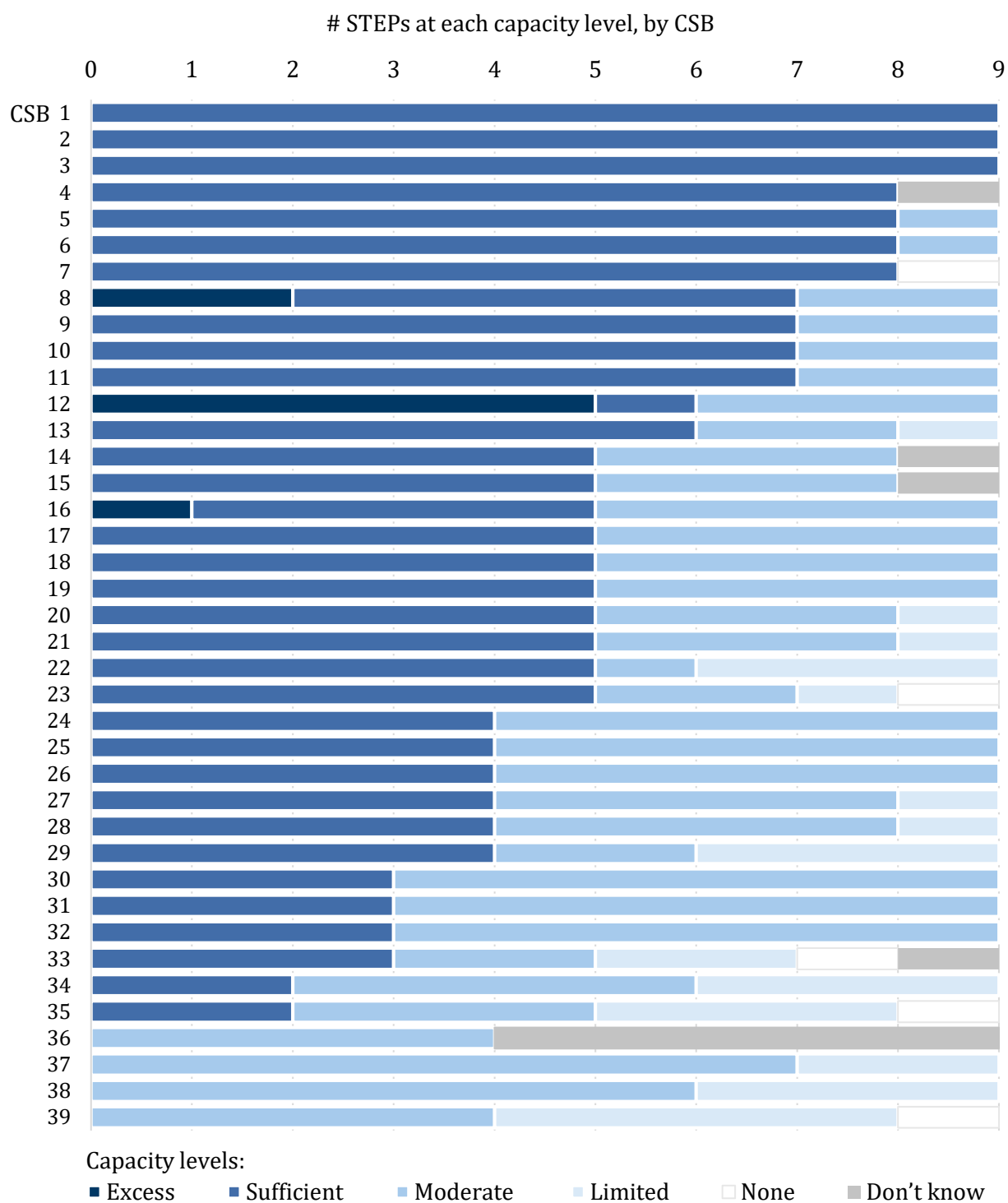
Note: None (<25% of need); Limited (25-50% of need); Moderate (50-75% of need); Sufficient (75-100% of need); Excess (>100% of need)

¹SMVF: service members, veterans, and families services

Source: BHC staff analysis of 2025 survey of CSBs (39 of 40 responding)

CSBs reported that capacity levels vary across STEPs, even within the same CSB (Figure 3-4). Only three CSBs report the same capacity level across all services, and 17 CSBs report capacity spanning three or more different levels across STEPs. Most CSBs report sufficient capacity for at least one STEP while simultaneously rating other STEPs as having moderate or limited capacity. This suggests that individual CSBs face different strengths and challenges in providing STEPs and may require different funding levels for different STEPs based on these strengths and challenges. Although a useful gauge, CSBs' perceived capacity remains an estimate and is insufficient for determining whether current service levels and funding are adequate to meet community needs.

Figure 3-4
Individual CSBs report varying capacity across STEPs



Note: None (<25% of need); Limited (25-50% of need); Moderate (50-75% of need); Sufficient (75-100% of need); Excess (>100% of need)

Source: BHC staff analysis of 2025 survey of CSBs (39 of 40 responding)

Robust and statewide needs assessment could help guide and optimize operational and funding decisions at the state and local levels

A needs assessment identifies to what extent existing services are meeting demand and the types and level of additional services required to fully meet each community's need for behavioral health services. Results from comprehensive needs assessments provide the foundation necessary to estimate how much additional funding is needed and for which services. These results can also be used to identify where the biggest gaps exist and ensure that resources are allocated to the CSBs and services with the greatest need.

Local needs assessments could help guide CSB operational and funding decisions

Most CSBs lack data about the exact needs of individuals within their coverage areas and are unable to make fully informed decisions about where to focus their operations and funding. Only four CSBs report having formal needs assessments. These four CSBs operate as CCBHCs and were required to conduct a comprehensive needs assessment as part of their CCBHC certification criteria. The needs assessment is an important component of CCBHC certification because it provides many benefits, such as:

- Targeting resources effectively by using population assessments to identify communities with the highest needs and/or disparities;
- Informing operational decisions by identifying specific community needs including staffing, language, service locations, service hours, and specific evidence-based practices;
- Establishing clear program direction by creating goals, specific criteria, and benchmarks for success; and
- Strengthening community engagement by facilitating collaboration with stakeholders and identifying desired services in the community.

Virginia's four CCBHCs highly value their needs assessments and consult them before making any operational or funding decisions. CCBHC staff described the needs assessments as invaluable to operating their CSB and serving their communities effectively. Two of Virginia's CCBHCs reported discovering surprising findings from their needs assessments, which led them to develop new services and programs to better serve their population.

Statewide formal needs assessment could help guide DBHDS funding allocation and measure access

No formal needs assessment has been conducted in Virginia related to CSB services or STEP-VA. A statewide needs assessment would examine the system-level issues that require state action and can evaluate how state-level policies impact service delivery across all CSBs, identify systemic barriers that impact access to care statewide, and determine what state infrastructure and resources are needed to support STEP-VA. A statewide needs assessment is also a pre-requisite for CCBHC certification and will need to be conducted if the state continues to move toward adopting this best practice model.

DBHDS was directed to assess the unmet needs for STEP-VA in the 2022-2024 Appropriation Act. The assessment had significant limitations that prevented it from providing the

comprehensive data needed to identify areas of unmet need across the state and to determine the specific resources required to meet community needs for STEP-VA services, according to DBHDS. These limitations included:

- Data quality issues—DBHDS received cost reports from only 37 of 40 CSBs, eight of which had incomplete information, and several more were filled out incorrectly;
- Lack of data validation—DBHDS was unable to compare submissions against certified financial statements or conduct follow-ups with CSBs that provided incorrect information;
- Methodology—the assessment relied on total population growth as a proxy for service needs rather than measuring actual demand for STEP-VA services.

In the absence of a statewide needs assessment, information gaps persist and limit the ability to evaluate the effectiveness of STEP-VA in Virginia. Without a needs assessment, it is not possible to determine the extent to which STEP-VA increases access to behavioral health services over time or whether the right services are available within each STEP and whether their provisions are maximized. CSBs now provide more services than before, but without baseline and current data on unmet need, it is unclear to what extent access continues to improve and where service gaps might remain.

It is also not possible to know whether funding is optimized and how effectively funding is allocated among STEP-VA services and CSBs. Virginia cannot identify whether some CSBs are unable to serve their populations at the level needed while others have excess capacity or if some CSBs need specific services that they do not currently offer.

OPTION 5

The General Assembly may wish to consider including \$2 million in the 2024-2026 Appropriation Act to conduct statewide and CSB-level comprehensive needs assessments.

The needs assessments should be conducted by a third-party and include all information needed to understand unmet need for behavioral health care in Virginia and fulfill the requirements of the CCBHC state needs assessment and community need assessments. DBHDS should convene a team to draft a request for proposal from third-party entities qualified to undertake a needs assessment of this magnitude; outline the scope and deliverable expected from the vendor; and review and select the winning proposal. The team should have equal representation between CSBs and DBHDS and include representatives from DMAS, and other relevant stakeholders.

4 Quality of STEP-VA services

One of the primary goals of the STEP-VA program has been to increase the quality of behavioral health services offered by Virginia's Community Services Boards (CSBs). Prior to STEP-VA, CSBs operated with more limited oversight by the Department of Behavioral Health and Developmental Services (DBHDS) and inconsistent quality standards, making it difficult to assess or ensure the quality of behavioral health services across Virginia. STEP-VA was designed to address this gap by establishing performance measures and benchmarks that would enable DBHDS and CSBs to monitor service quality and identify areas for improvement, while giving DBHDS a systematic way to hold CSBs accountable for delivering high-quality services. Developing a meaningful performance measurement system has proven challenging, but measures are now available for all STEPs, and a portion have accompanying benchmarks.

DBHDS has established processes designed to support CSBs while also holding them accountable. When a CSB's performance does not meet established benchmarks, DBHDS may initiate technical assistance, which can include site visits and office hours. If performance does not improve after at least six months, DBHDS may work with the CSB to develop a performance improvement plan (PIP) that identifies specific action steps, timelines, and resources needed to meet benchmarks. DBHDS is also working with CSBs to address data accuracy issues that may contribute to apparent underperformance and to resolve any data discrepancies as they roll out the new Enterprise Data Warehouse (EDW) system.

Current performance metrics focus on program requirements and include limited outcome measures

DBHDS has established performance measures for STEP-VA to monitor implementation and quality across CSBs; however, the current metrics primarily track compliance with program requirements and do not evaluate whether STEP-VA services improve the lives of individuals receiving care. Even when outcome measures exist, they capture narrow aspects of care and do not provide sufficient insight into service quality.

Performance measures have been established for all STEPs, but only a subset have corresponding benchmarks

Performance measures have been developed for every STEP and were included in the fiscal year (FY) 2026 CSB performance contract (Table 4-1). This is an improvement compared to 2023, when final performance measures had been adopted for only four of nine STEPs. There are now 15 performance measures for STEP-VA.

As of 2025, benchmarks had been established for only seven of the 15 performance measures (Table 4-2). Without benchmarks, it is difficult to determine whether CSB performance is adequate, and to identify which CSBs may require technical assistance. DBHDS has been collecting preliminary data that will be used to finalize benchmarks for four additional measures in FY26, and the agency has

committed to developing benchmarks for the four remaining measures by the start of FY27, based on interviews with DBHDS staff.

Table 4-1

Performance measures have been established for every STEP in FY26 performance contract

STEP	Measures included in FY23 performance contract	Measures included in FY26 performance contract
Same-day access	▪ SDA appointment offered within 10 days ▪ SDA appointment kept within 30 days	▪ SDA appointment kept within 30 days ▪ I-SERV¹
Primary care screening	No established measures	▪ Antipsychotic metabolic screening ▪ Primary care screening for SMI/SED
Crisis services	No established measures	▪ Mobile crisis arrival time ▪ Mobile crisis community retention
Outpatient services	▪ Annual outpatient trauma training	▪ Annual outpatient trauma training ▪ SUD¹ engagement ▪ DLA-20²
Peer & family support services	▪ Peer FTEs (total) ▪ Peer support service units	▪ Peer FTEs (total) ▪ Peer FTEs (STEP-VA funded) ▪ Peer certification and registration ▪ DLA-20²
SMVF ¹ services	▪ Military/veterans cultural competency training ▪ SMVF identification ▪ SMVF referral	▪ Military/veterans cultural competency training ▪ SMVF identification ▪ Columbia suicide screening
Psychiatric rehabilitation	No established measures	DLA-20 ²
Care coordination	No established measures	DLA-20 ²
Case management	No established measures	DLA-20 ²

¹I-SERV: measures time it takes for clients to be evaluated and access services from point of first contact; SUD: substance use disorder; SMVF: service members, veterans, and families

²DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of CSB performance contracts (FY23-FY26)

Table 4-2
Benchmarks have been established for five STEP-VA performance measures

Performance measure	Definition	Benchmark
SDA ¹ appointment kept	% of individuals who received SDA assessment and follow-up services within 30 calendar days	70%
SUD ¹ engagement	% of individuals who attend at least 2 follow up SUD services within 30 days of diagnosis	65%
Military/veterans cultural competency training	% of staff completing Military Cultural Competence Training every 3 years	95%
Identifying SMVF ¹ members	% of health records with a valid entry for the Military Status demographic variable	90%
Columbia suicide screening	% of SMVF individuals that receive Columbia suicide screening within 30 days	86%
Annual outpatient training	% of staff meeting 8-hour minimum outpatient training requirement	95%
Peer certification and registration	% of Peer Support Service FTEs that obtain certification are registered	100%
Mobile crisis arrival time	% of mobile crisis calls responded to within 1-2 hours from dispatch	Final in FY26
Mobile crisis community retention	% of mobile crisis responses that maintained community setting	Final in FY26
Peer FTEs (STEP-VA funded)	# of Peer Support Services FTEs funded by STEP-VA allocations	Final in FY26
Peer FTEs (total)	# of Peer Support Services FTEs from all funding sources	Final in FY26
I-SERV	% of new individuals evaluated within 10 business days of first contact	by FY27
Antipsychotic metabolic screening	% of individuals prescribed antipsychotics who receive a metabolic screening within 1 year	by FY27
Primary care screening	% of adults with SMI ¹ and children with SED ¹ who receive annual primary care screening	by FY27
DLA-20 ²	% of individuals who demonstrate improved in DLA-20 score over 6-month period	by FY27

¹SDA: same-day access; SMI: serious mental illness; SMVF: service members, veterans, and families services; SED: serious emotional disturbance; SUD: substance use disorder

²DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of CSB performance contract (FY26)

Most STEP-VA performance measures evaluate program requirements and processes rather than individual outcomes

Most STEP-VA performance measures pertain to program requirements and processes, which gauge the ability of CSBs to comply with standards rather than the impact of their services on clients' outcomes (Table 4-3). Most CSB staff interviewed for this study expressed frustration that performance continues to be measured by STEP rather than holistically for each individual. They also indicated that many current measures do not capture the quality of their services, and that they do not align with how they deliver care.

Program requirements measure whether CSBs have implemented the administrative and structural components of STEP-VA. For example, some program requirements track whether CSBs are completing specific types of screenings, staff trainings, and documentation tasks. Most of these measures align with Certified Community Behavioral Health Clinic (CCBHC) program requirements. Process measures track whether services are delivered within the required timeframes. In contrast, outcome measures assess whether STEP-VA services are improving individual's lives and track information such as changes in well-being. Program requirements and process measures were appropriate while STEP-VA was being implemented to ensure that STEPs were rolled out successfully. Now that all STEPs have been implemented, a greater focus should be placed on outcomes.

Table 4-3
STEP-VA performance measures have emphasized compliance over performance

Measures compliance		Measures performance
Program requirements (9)	Process measures (4)	Outcome measures (2)
▪ Primary care screening ▪ Antipsychotic metabolic screening ▪ Military/veterans cultural competency training ▪ Identifying SMVF¹ members ▪ Columbia suicide screening ▪ Annual outpatient training ▪ Peer FTEs¹ (STEP-VA funded) ▪ Peer FTEs (total) ▪ Peer certification and registration	▪ I-SERV ▪ SDA¹ appointment kept ▪ Mobile crisis arrival time ▪ SUD¹ engagement	▪ DLA-20² ▪ Mobile crisis community retention

¹SMVF: service members, veterans, and families services; SDA: same day access; SUD: substance use disorder

²DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of CSB performance contract (FY26)

Measuring the performance of each STEP individually may have inherently led to a greater emphasis on compliance rather than outcomes. DBHDS and several CSBs believe there is an expectation that performance should be measured by STEP to align with how STEP-VA funding is allocated, although there is no statutory or budgetary requirement to do so. Program requirements, such as those used by CCBHCs, can easily be measured and reported by STEP to satisfy expectations for STEP-specific measures. However, there is a fundamental mismatch between measuring performance for each STEP and assessing the outcomes of individuals, because of the way behavioral health services are actually delivered. Individuals with behavioral health conditions often receive services across multiple STEPs simultaneously, making it impossible to attribute their outcomes to one specific STEP.

Program requirements and process measures are useful to ensure that all the elements needed to achieve good outcomes are in place; however, they are not sufficient to measure the quality of services. In order to provide a robust analysis of program quality, a program needs a balance of program requirements, process measures, and outcome measures. STEP-VA currently skews towards having too few outcome measures (two) compared to program requirements (eight) and process measures (four).

STEP-VA performance measures provide limited information about program quality and effectiveness

STEP-VA has only two outcome measures (mobile crisis community retention and DLA-20) that assess whether services improve individuals' conditions or functioning, which is not sufficient for a robust evaluation of the program's quality. In contrast, CCBHC uses six measures to capture more holistic and comprehensive outcome information such as depression remission, adherence to medications, and readmissions (Table 4-4).

Mobile crisis community retention measures how many individuals were able to stay in the community during and after a crisis. This measure is useful; however, it only captures outcomes for individuals who receive crisis services, a small segment of the population who receive services across all nine STEPs. The second outcome measure considers the change in individuals' scores on the Daily Living Activities-20 (DLA-20) assessment instrument. This metric is the primary outcome measure for multiple STEPs. The DLA-20 is a questionnaire that asks individuals to rate their ability to perform 20 everyday tasks, such as managing personal hygiene, handling finances, maintaining relationships, and coping with stress. Higher scores indicate better functioning, and lower scores indicate greater difficulty with daily activities. By comparing DLA-20 scores before and after receiving services, it is possible to measure whether individuals are better able to function independently in their daily lives. Improvement on the DLA-20 serves as an indicator of treatment effectiveness. However, the DLA-20 has been criticized as inappropriate for the population accessing behavioral health services. It lacks standardized scoring for individuals with substance use disorder (SUD) and requires quarterly face-to-face assessments that places additional burden on service providers. In addition, DBHDS currently has limited insight into the impact of STEP-VA services on DLA-20 outcomes, because they can only access summary information rather than granular data that would be needed for a robust quality assessment. The inherent limitations of the tool and limited access to DLA-20 data suggest that this outcome measure may not be the best indicator of STEP-VA service quality. To address concerns over the DLA-20, DBHDS has piloted and is planning to start using a new tool in FY27, the World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) short version.

Table 4-4

CCBHC has more comprehensive outcome measures than STEP-VA (FY26)

STEP-VA outcome measures (2)	CCBHC clinic required outcome measures (6)
- DLA-20¹ - Mobile crisis community retention	- Depression remission at 6 months - Adherence to pharmacotherapy for individuals with Opioid Use Disorder - Adherence to antipsychotic medications for individuals with schizophrenia - Readmissions rates - Change in Hemoglobin A1c for patients with diabetes - Initiation and engagement of alcohol and other drug dependence treatment

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of CSB performance contract (FY26) and CCBHC certification criteria

Data availability and accuracy still preclude a robust evaluation of STEP-VA quality

The availability and accuracy of data continue to limit the development and usability of comprehensive performance measures. The development of performance measures was initially constrained by the inadequate data capabilities of the Community Consumer Submission 3 (CCS-3) data system, but it continues to face challenges due to limitations of the new Enterprise Data Warehouse (EDW) system.

STEP-VA performance measures were initially selected and operationalized based on the data that was collected through the CCS-3. CCS-3 data lagged by approximately three months and was very burdensome to collect and report. Information was often inconsistent among CSBs due to a lack of standardized definitions and was frequently flawed.

In response to the difficulties with the CCS-3, DBHDS transitioned to the EDW as part of a broader system modernization effort. The EDW is a centralized data system designed to create a single behavioral health data warehouse, and it pulls data directly from CSB systems. All 40 CSBs were transitioned to the EDW in July 2025, and all FY26 performance measures for STEP-VA will be calculated using information from the EDW. There are many positive elements to this transition, including more accurate and real-time data coming from CSBs. The EDW also removes some data reporting burden from CSBs since data is collected directly from their electronic health records and does not require a manual upload.

Still, the current version of the EDW does not yet have all the data fields and capabilities needed for comprehensive performance measures. No new data fields were added during the development and transition to the EDW, and it will take time for new data fields to be added to support new measures.

DBHDS and CSBs need to act swiftly to identify additional data fields that should be collected so they can be integrated into the next version of the system in 2026.

CSB performance on most measures is unclear

CSB performance on STEP-VA services remains difficult to assess because of issues related to the usability and accuracy of available data. Only three performance measures (same day access (SDA) appointment kept, Columbia screening, and SUD engagement) have sufficient validated data to estimate performance, according to DBHDS and CSB staff, and data from these measures shows improvement. Performance on the remaining measures is still unknown.

Performance on three STEP-VA measures shows improvement

Three measures have sufficient validated data to estimate performance: (1) SDA appointment kept, (2) Columbia screening, (3) SUD engagement. These measures are three of the most established STEP-VA measures, and both DBHDS and CSBs agree that the data is accurate enough to estimate performance.

SDA appointments kept

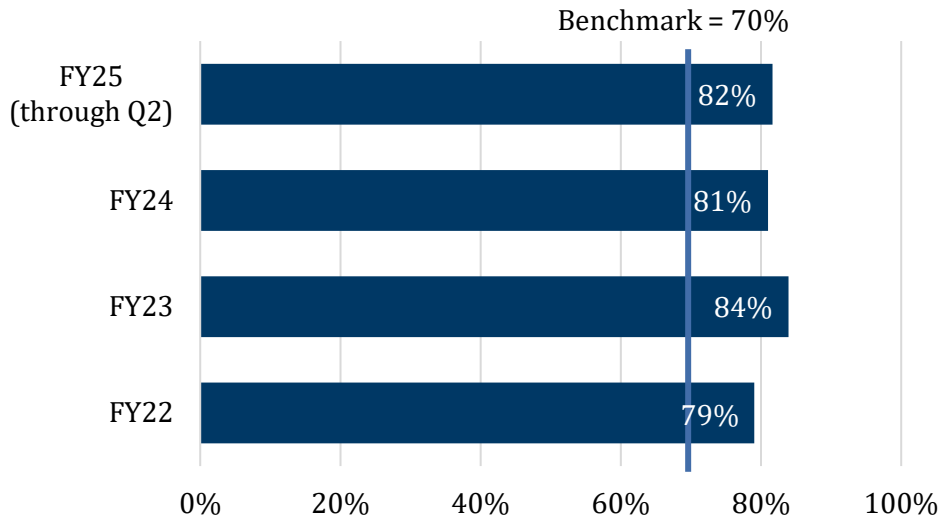
Since FY22, performance on all three measures has improved. Statewide, the proportion of individuals who kept their first appointment within 30 days of an SDA assessment increased by three percentage points between FY22 and the second quarter (Q2) of FY25 (Figure 4-1). About three-quarters of CSBs (31) met the 70 percent benchmark for this measure in FY25 Q2 (Figure 4-2). However, performance on this metric remains a partial measure of SDA quality, because many of the factors that can impact someone's ability to keep an appointment are outside of CSBs' direct control. For example, transportation barriers, work schedules, childcare responsibilities, and individual choice all affect whether individuals attend their scheduled appointment.

Columbia screenings

Statewide, nearly three-quarters of service members and veterans received a Columbia screening in the first half of FY25, which represents an increase of 11 percentage points compared to FY22 (Figure 4-3). However, statewide performance remains below the 86 percent benchmark. Only 42 percent of CSBs (17) met the benchmark for this measure in FY25 Q2 (Figure 4-4). The benchmark for this measure increased from 60 percent in FY22 to 86 percent in FY24, thereby requiring CSBs to achieve a 26 percentage point improvement in screening rates in order to meet the new benchmark. CSBs report that Virginia's current 86 percent benchmark exceeds typical national screening rates for this population. The Columbia screening identifies individuals at risk for suicide, enabling early intervention and safety planning. Although this screening is useful for identifying at-risk individuals, STEP-VA does not currently track whether those identified receive appropriate follow-up care or experience reduced suicide risk over time. As a result, the impact of STEP-VA services on preventing self-harm and suicide remains unmeasured.

Figure 4-1

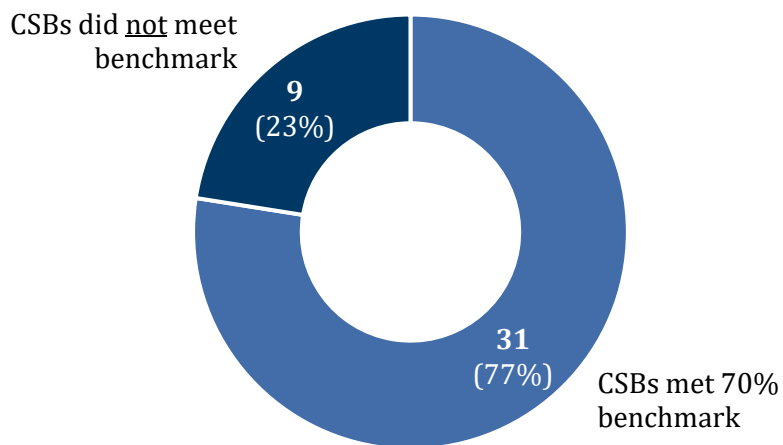
Proportion of individuals who kept their first appointment within 30 days of their assessment improved over time and has met 70 percent benchmark since FY22



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

Figure 4-2

Most CSBs (31) met the 70 percent benchmark for individuals who kept their first appointment within 30 days of their assessment (FY25 through Q2)



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

SUD engagement

Statewide, nearly two-thirds of individuals attended at least two SUD services within 30 days of diagnosis in the first half of FY25, a seven percentage point increase compared to FY22 (Figure 4-5). About three-quarters of CSBs (31) met the 50 percent benchmark for this measure in FY25 Q2 (Figure 4-6). Early engagement in SUD treatment is associated with improved retention and recovery outcomes; however, STEP-VA does not currently track whether individuals who attend these early services continue in treatment or achieve recovery milestones. Therefore, it is unknown whether early service engagement has led to improved individual outcomes.

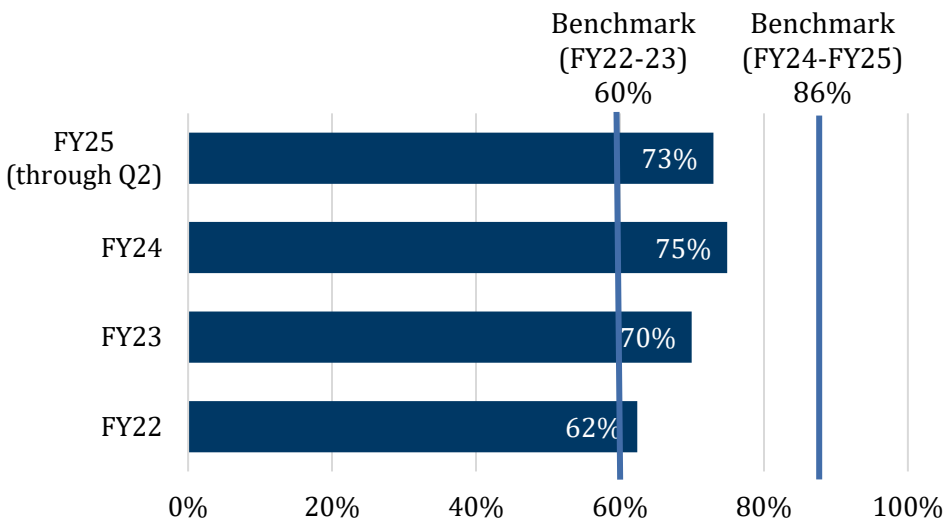
CSB data for the remaining performance measures is incomplete

Sufficient, validated data does not exist to assess performance on the other 12 STEP-VA measures currently in place. Many of these measures were only recently incorporated into the CSB performance contract, and more time is needed to collect enough data to establish benchmarks and to fix any accuracy issues that may affect the validity of the data. DBHDS is currently collecting baseline data in order to establish benchmarks for these measures. Until then, there are no standards against which to measure CSB performance.

Preliminary data is available for some of the 12 performance measures and may provide some insights on performance. This information is available in Appendix C. However, this data should be interpreted cautiously given the ongoing changes to performance measures, data accuracy challenges, and the recent transition to a new data system.

Figure 4-3

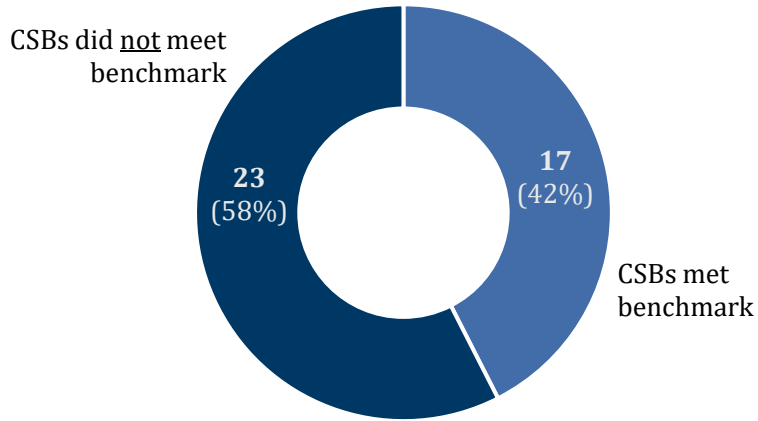
Statewide performance on Columbia screening measure has improved, but remains below the 86 percent benchmark



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

Figure 4-4

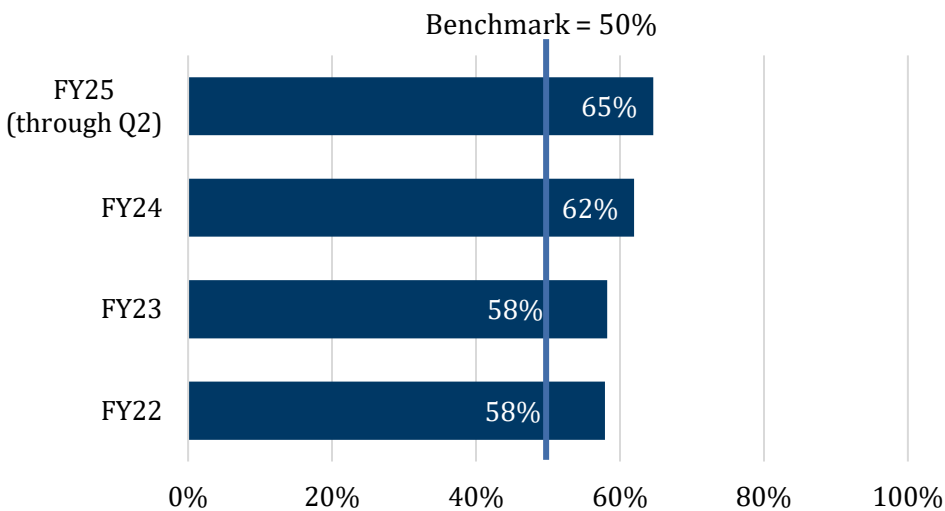
42 percent of CSBs (17) met 86 percent benchmark for SMVF individuals who received a Columbia screening (FY25 through Q2)



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

Figure 4-5

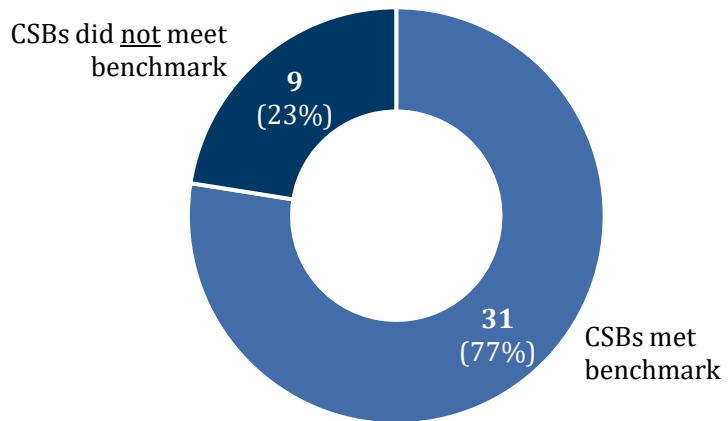
Statewide performance on engagement in SUD treatment has improved and met 50 percent benchmark since FY22



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

Figure 4-6

Most CSBs (31 of 40) met the 50 percent benchmark for engagement in SUD treatment individuals who kept first appointment after SDA assessment within 30 days (FY25 Q2)



Source: BHC staff analysis of CSB performance data collected by DBHDS (FY22-FY25 Q2)

Recommendations and options: STEP-VA performance monitoring and evaluation

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

The General Assembly may wish to consider appropriating STEP-VA funding as one amount rather than setting out appropriations for each STEP, beginning with the 2026-2028 Appropriation Act.

RECOMMENDATION 2

The Department of Behavioral Health and Developmental Services should make necessary changes to the CSB performance contract to eliminate STEP-specific distribution of funds.

Options

OPTION 1

The General Assembly may wish to consider directing the Secretary of Health and Human Resources to convene a taskforce to develop a proposed strategic vision for STEP-VA. The taskforce should at a minimum include representatives from the Department of Behavioral Health and Developmental Services, Community Services Boards, Virginia Association of Community-Based Providers, and the Department of Medical Assistance Services, and should report the proposed strategic vision to the Behavioral Health Commission (BHC) for legislative input by July 1, 2027, with a progress update by November 1, 2026. The Secretary should facilitate a process for incorporating public input into the strategic vision adopted by the BHC and make a final proposal available to the BHC no later than November 1, 2027.

OPTION 2

The General Assembly may wish to consider amending §37.2-500 of the Code of Virginia to codify the strategic vision of STEP-VA during the 2028 session.

OPTION 3

The General Assembly may wish to consider directing the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Department of Medical Assistance Services (DMAS), to assist a representative sample of Community Services Boards (CSBs) with conducting an analysis of their Medicaid revenue. This analysis should examine enrollment in Medicaid compared to eligibility, MCO denial rates; time spent on billing, Medicaid losses experienced on STEP-VA services, and collections from patients, as well as the primary factors driving results from the analysis. DBHDS and DMAS should work with CSBs to create an action plan that identifies the changes needed to maximize Medicaid revenue, how changes will be implemented, and on what timeline. The action plan should be completed and communicated to the Behavioral Health Commission by December 1, 2026.

OPTION 4

The General Assembly may wish to consider directing the Department of Medical Assistance Services (DMAS) to (i) identify the steps necessary for Virginia to effectively and efficiently transition to a prospective payment system (PPS) as required to fully adopt the CCBHC model, and (ii) estimate any fiscal impact to the state and to Community Services Boards (CSBs), and (iii) report findings to the House Appropriations Committee, the Senate Finance and Appropriations Committee, and the Behavioral Health Commission by December 1, 2026.

As part of this report, DMAS should estimate a timeframe for transitioning to PPS and examine the actions needed with respect to rate-setting; approval process from the Centers for Medicare and Medicaid Services; Managed Care Organization (MCO) contract modifications; electronic health records and billing system updates; and any other necessary changes. DMAS should also identify ways to reduce the billing and reimbursement challenges that have been experienced by CSBs under the current Medicaid model.

OPTION 5

The General Assembly may wish to consider including \$2 million in the 2024-2026 Appropriation Act to conduct statewide and CSB-level comprehensive needs assessments.

The needs assessments should be conducted by a third-party and include all information needed to understand unmet need for behavioral health care in Virginia and fulfill the requirements of the CCBHC state needs assessment and community need assessments. DBHDS should convene a team to draft a Request for Proposal (RFP) from third-party entities qualified to undertake a needs assessment of this magnitude; outline the scope and deliverable expected from the vendor; and review and select the winning proposal. The team should have equal representation between CSBs and DBHDS and include representatives from DMAS, and other relevant stakeholders.

Appendix A: Research activities and methods

Key research activities performed for this study included:

- Semi-structured interviews with leadership and staff of: the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards (CSBs), and the Virginia Association of Community Services Boards (VACSB);
- Site visits to CSBs;
- Surveys of CSBs;
- Analysis of DBHDS data and CSB data;
- Reviews of CSB performance contracts;
- Reviews of previous reports on STEP-VA and Virginia's CSB system;
- Reviews of national literature and federal Certified Community Behavioral Health Clinic (CCBHC) guidance; and
- Reviews of state documentation, such as those related to laws, regulations, and policies relevant to the provision of STEP-VA services in Virginia.

Interviews and site visits

Structured interviews were a key research method for this report. BHC staff conducted about 15 interviews and three site visits. Key interviewees included:

- Leadership and staff of DBHDS;
- Leadership and staff of CSBs;
- Leadership and staff of VACSB.

Leadership and staff of DBHDS

BHC staff conducted five interviews with DBHDS leadership and staff. Topics varied across interviews but were primarily designed to understand DBHDS's oversight functions, including ongoing monitoring, training and technical assistance efforts, and other support activities. DBHDS staff were also asked for their perspectives on opportunities to improve STEP-VA.

Leadership and staff of CSBs

BHC staff conducted 10 individual and group interviews with directors, administrators, and clinical staff of Virginia's CSBs in different areas of the state and of various sizes, including:

- Highlands (site visit)
- Mount Rogers – CCBHC (site visit)
- Prince William County
- Rappahannock

- Richmond - CCBHC (site visit)
- Virginia Beach

Interview topics focused on various aspects of STEP-VA, including funding, implementation, access to services, performance measurement, barriers, and satisfaction with DBHDS guidance. CSB staff were also asked for their perspectives on opportunities to improve STEP-VA.

Leadership and members of VACSB

BHC staff conducted interviews with leadership and several CSB members of VACSB, which were designed to understand CSB operations, CSB costs and revenue, performance measures, challenges with data integrity, role in STEP-VA, and opportunities to improve STEP-VA.

Survey

For this study, BHC staff conducted a survey of CSBs. The survey was sent electronically via VACSB to executive directors of all 40 CSBs. The survey was designed to collect information about where STEP-VA services are available and to collect CSB perspectives on the issues faced in providing and expanding STEP-VA services. BHC staff received responses from 39 of 40 CSBs. The 39 CSBs that responded provide services to 99.9% of Virginia residents and are varied in location and size.

Data collection and analysis

BHC staff collected several types of data from DBHDS, CSBs, and VACSB to analyze for this report. Staff received CSB-level funding and performance data from DBHDS on all STEPs from FY17 to FY25 Q2. CSBs also submitted financial data related to STEP-VA services from FY17 to FY24, including revenue by source, and expenditures by billing category, as well as information on the number of individuals served and daily visits.

Not all CSBs provided data on the unduplicated number of individuals they served and reported instead a duplicated total by billing category. Eighteen CSBs provided complete unduplicated totals for individuals served across billing categories, while the remaining 18 CSBs only reported unduplicated counts for specific billing categories. To estimate the total unduplicated number of individuals receiving STEP-VA services statewide, BHC staff imputed missing data on unduplicated individuals using information from the 18 CSBs that provided complete data. Staff calculated the ratio of unduplicated individuals to the duplicated total for the 18 CSBs with complete information; this ratio was applied to the number of duplicated individuals reported by the other 18 CSBs with incomplete data, to solve for the estimated number of unduplicated individuals they served across billing categories. The final statewide estimate combined the known unduplicated totals and the imputed unduplicated totals.

Document and policy review

BHC staff reviewed numerous other documents and the research literature pertaining to STEP-VA and behavioral health services, including:

Appendix A: Research activities and methods

- CSB performance contracts from FY22 to FY26;
- STEP-VA annual reports;
- State agency reports related to STEP-VA;
- Virginia laws, regulations, and policies related to STEP-VA;
- National literature on behavioral health services;
- Federal requirements and guidance related to CCBHC;
- Federal guidance on Medicaid prospective payment system (PPS), and other states' laws, regulations, policies, and initiatives to implement PPS.

Appendix B: STEP-VA statute

Statute § 37.2-500. Purpose; community services board; services to be provided.

- (A) The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, developmental, and substance abuse services in the Commonwealth, may provide funds to assist any city or county or any combinations of cities or counties or cities and counties in the provision of these services. Every city or county shall establish a community services board by itself or in any combination with other cities and counties, unless it establishes a behavioral health authority pursuant to Chapter 6 (§ 37.2-600 et seq.). In order to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care, the community services board shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.
- (B) The core of services provided by community services boards within the cities and counties that they serve shall include:
- (1) Emergency services;
 - (2) Same-day mental health screening services;
 - (3) Outpatient primary care screening and monitoring services for physical health indicators and health risks and follow-up services for individuals identified as being in need of assistance with overcoming barriers to accessing primary health services, including developing linkages to primary health care providers; and
 - (4) Subject to the availability of funds appropriated for them, case management services.
- (C) Subject to the availability of funds appropriated for them, the core of services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, developmental, and substance abuse services necessary to provide individualized services and supports to persons with mental illness, developmental disabilities, or substance abuse. Community services boards may establish crisis stabilization units that provide residential crisis stabilization services.
- (D) The purpose of behavioral health services provided by community services boards shall be to enable individuals who have a mental illness or substance use disorder that significantly impairs their functioning to access effective, timely, and cost-efficient services that help them (i) overcome or manage functional impairments caused by the mental illness or substance use disorder and (ii) remain in the community to the greatest extent possible, consistent with the individual's well-being and public safety.

- (E) Every city or county or any combination of cities and counties that has established a community services board, in consultation with that board, shall designate it as an operating community services board, an administrative policy community services board, or a local government department with a policy-advisory community services board. The governing body of each city or county that established the community services board may change this designation at any time by ordinance. In the case of a community services board established by more than one city or county, the decision to change this designation shall be the unanimous decision of all governing bodies.
- (F) A community services board may enter into contracts with private providers to ensure the delivery of services pursuant to this article.

Acts of Assembly, 2017 Session, Chapter 607

Be it enacted by the General Assembly of Virginia:

- (1) That §§ 37.2-500 and 37.2-601 of the Code of Virginia are amended and reenacted as follows: § 37.2-500. Purpose; community services board; services to be provided.
 - (A) The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, developmental, and substance abuse services in the Commonwealth, may provide funds to assist any city or county or any combinations of cities or counties or cities and counties in the provision of these services. Every county or city shall establish a community services board by itself or in any combination with other cities and counties, unless it establishes a behavioral health authority pursuant to Chapter 6 (§ 37.2-600 et seq.). Every county or city or any combination of cities and counties that has established a community services board, in consultation with that board, shall designate it as an operating community services board, an administrative policy community services board or a local government department with a policy-advisory community services board. The governing body of each city or county that established the community services board may change this designation at any time by ordinance. In the case of a community services board established by more than one city or county, the decision to change this designation shall be the unanimous decision of all governing bodies.
 - (B) The core of services provided by community services boards within the cities and counties that they serve shall include:
 - (1) Emergency services;
 - (2) Same-day mental health screening services;
 - (3) Outpatient primary care screening and monitoring services for physical health indicators and health risks and follow-up services for individuals identified as being in need of assistance with overcoming barriers to accessing primary health services, including developing linkages to primary health care providers; and,
 - (4) Subject to the availability of funds appropriated for them, case management services.
 - (C) The core of services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate

mental health, developmental, and substance abuse services necessary to provide individualized services and supports to persons with mental illness, intellectual disability, or substance abuse. Community services boards may establish crisis stabilization units that provide residential crisis stabilization services.

- (D) In order to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care, the community services board shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.

§ 37.2-601. Behavioral health authorities; purpose.

- (A) The Department, for the purposes of establishing, maintaining, and promoting the development of behavioral health services in the Commonwealth, may provide funds to assist certain cities or counties in the provision of these services.

- (B) The governing body of the Cities of Virginia Beach or Richmond or the County of Chesterfield may establish a behavioral health authority and shall declare its intention to do so by resolution.

- (C) The behavioral health services provided by behavioral health authorities within the cities or counties they serve shall include:

- (1) Emergency services;
- (2) Same-day mental health screening services;
- (3) Outpatient primary care screening and monitoring services for physical health indicators and health risks and follow-up services for individuals identified as being in need of assistance with overcoming barriers to accessing primary health services, including developing linkages to primary health care providers; and,
- (4) Subject to the availability of funds appropriated for them, case management services.

- (D) The behavioral health services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, developmental, and substance abuse services necessary to provide individualized services and supports to persons with mental illness, intellectual disability, or substance abuse. Behavioral health authorities may establish crisis stabilization units that provide residential crisis stabilization services.

- (E) In order to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care, the behavioral health authority shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.

- (2) That the provisions of the first enactment of this act shall become effective on July 1, 2019.

- (3) That, effective July 1, 2021, the core of services provided by community services boards and behavioral health authorities within cities and counties that they serve shall include, in addition to those set forth in subdivisions B 1, 2, and 3 of § 37.2-500 of the Code of Virginia, as amended by this act, and subdivisions C 1, 2, and 3 of § 37.2-601 of the Code

of Virginia, as amended by this act, respectively, (i) crisis services for individuals with mental health or substance use disorders, (ii) outpatient mental health and substance abuse services, (iii) psychiatric rehabilitation services, (iv) peer support and family support services, (v) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, (vi) care coordination services, and (vii) case management services.

- (4) That the Department of Behavioral Health and Developmental Services shall report by December 1 of each year to the General Assembly regarding progress in the implementation of the provisions of this act

Appendix C: Performance data on STEP-VA service categories

Same day access

Purpose

The same day access (SDA) service category is intended to ensure that every person who seeks behavioral health services can access the services they need when they need them by:

- Conducting an initial triage screening on the same day that the person appears at the CSB for services
- Scheduling initial appointment for services within 10 days of SDA assessment

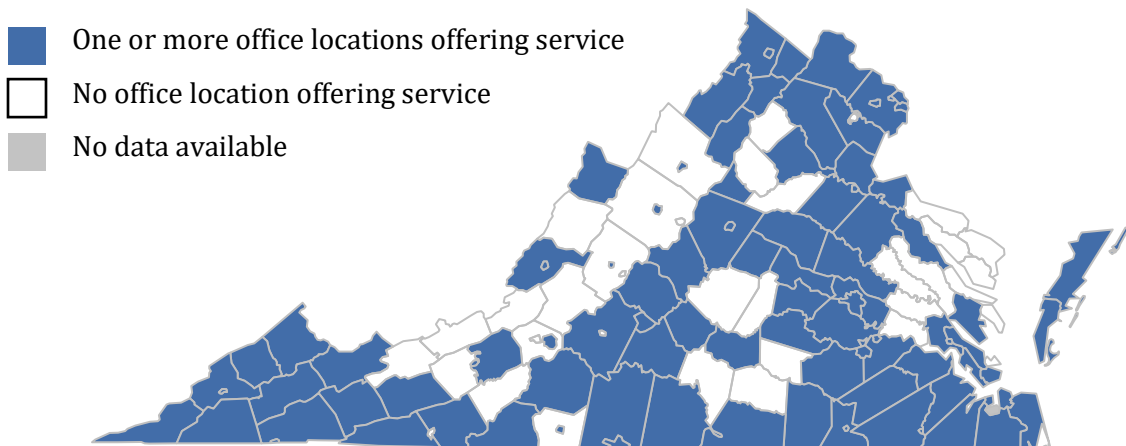
\$13.1M
appropriated in
FY26

\$95.9M
appropriated
FY18-FY26

Access

Exhibit B-1

Same day access is available at office locations in 95 localities (71 percent)



Performance

FY25 performance measures	Benchmark	FY24 performance data
SDA appointment kept within 30 days	70%	31 CSBs met benchmark
I-SERV ¹	by FY27	Baseline data collected
Initial evaluation within 10 business days	86%	9 CSBs met benchmark

¹I-SERV: measures time it takes for clients to be evaluated and access services from point of first contact
Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Primary care screening

Purpose

The primary care screening service category is intended to improve health outcomes for individuals receiving CSB services by:

- Conducting a primary care assessment to identify physical health risks, and
- Providing connections to health care services to address physical health risks.

\$9.1M
appropriated in
FY26

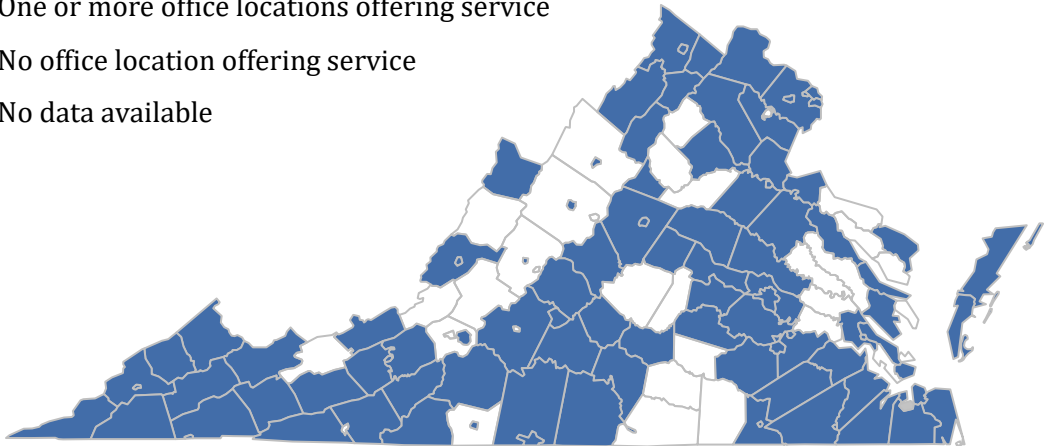
\$59.0M
appropriated
FY18-FY26

Access

Exhibit B-2

Primary care screening is available at office locations in 98 localities (74 percent)

- One or more office locations offering service
- No office location offering service
- No data available



Performance

2025 performance measure	Benchmark	FY24 performance
Primary care screening for SMI/SED	Establish by FY27	41% of individuals received screening statewide
Antipsychotic metabolic screening	Establish by FY27	50% of individuals received screening statewide

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Outpatient services

Purpose

The outpatient services service category is intended to expand CSB outpatient capacity and quality by:

- Allowing CSBs to hire additional clinicians to provide outpatient services
- Improving hiring and retention of clinicians by providing salary adjustments and retention bonus

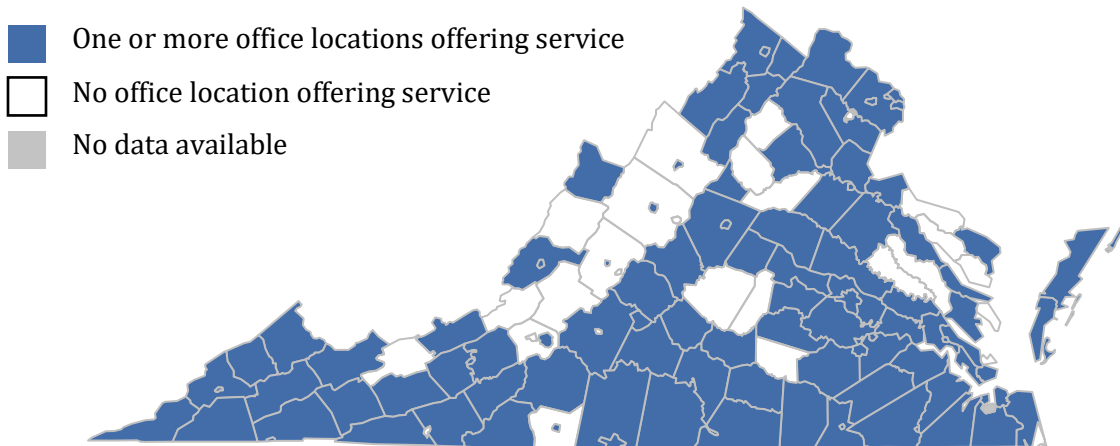
\$27.9M
appropriated in
FY26

\$151.5M
appropriated
FY20-FY26

Access

Exhibit B-3

Outpatient services are available at office locations in 104 (78 percent of) localities



Performance

FY25 performance measure	Benchmark	FY24 performance
Annual outpatient training	95%	13 CSBs met benchmark
Trauma training	Establish by FY27	Baseline data collected
DLA-20 ¹	Establish by FY27 (FY24 target 35%)	25 CSBs met target (adult)

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Crisis services

Purpose

The STEP-VA-funded crisis service category is intended to expand access to a comprehensive continuum of behavioral health crisis services, including:

- Crisis call center,
- Mobile crisis response teams, and
- Crisis stabilization services

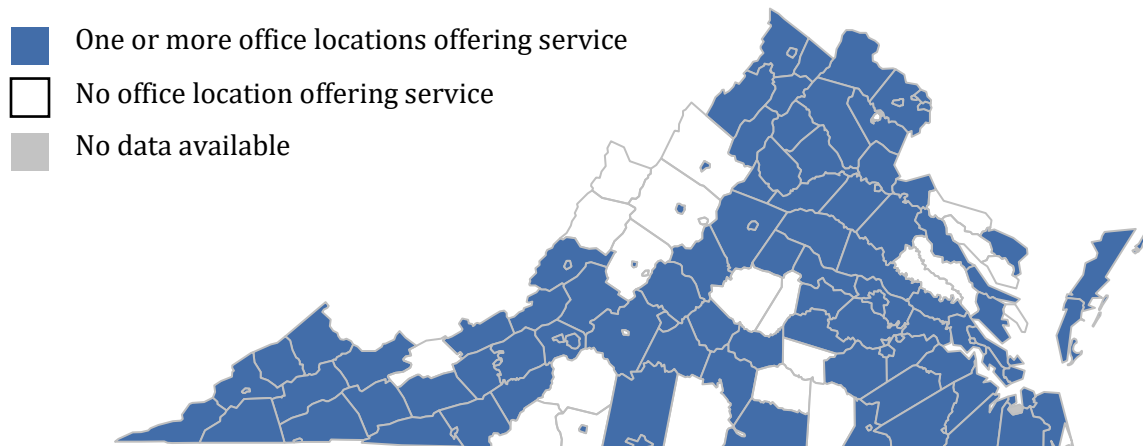
\$40.9M
appropriated in
FY26

\$214.8M
appropriated
FY20-FY26

Access

Exhibit B-4

Crisis services are available at office locations in 107 (80 percent of) localities



Performance

FY25 performance measure	Benchmark	FY25 performance
Mobile crisis arrival time	Finalize in FY26	Baseline data collected
Mobile crisis community retention	Finalize in FY26	Baseline data collected

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Peer and family support services

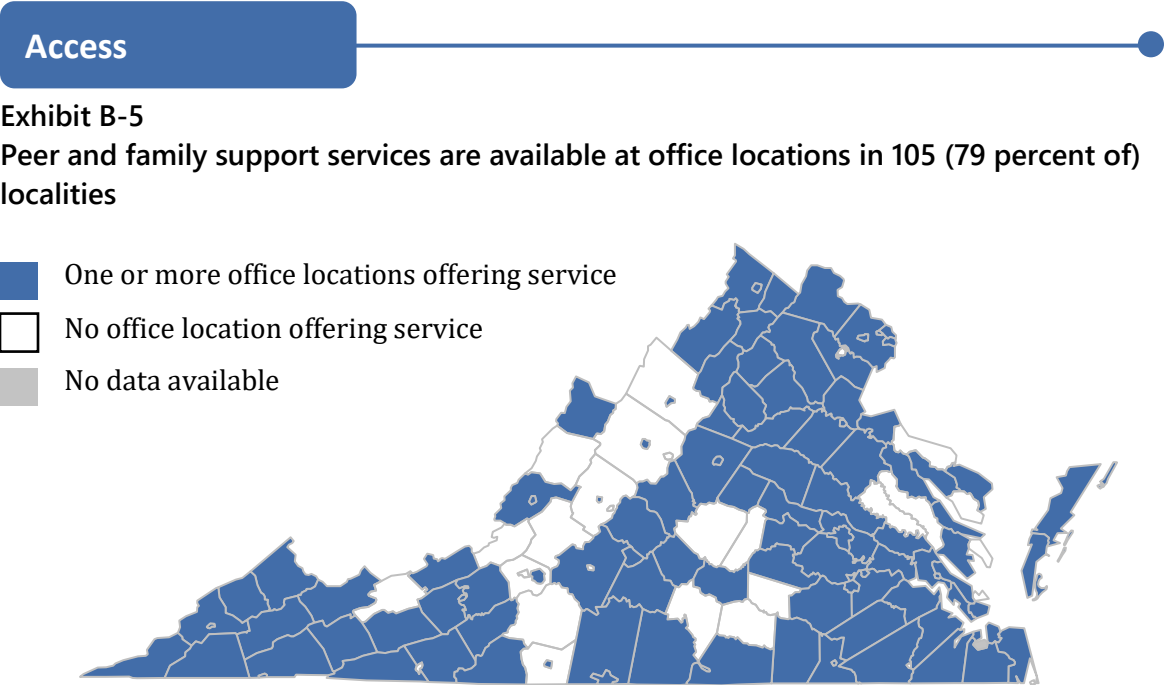
Purpose

The peer and family support services service category is intended to improve outcomes for individuals receiving CSB services by providing person-centered, strength-based, recovery-oriented supports including:

- Peer support services, and
- Family support services or parents or caregivers of youth with behavioral health service needs

\$5.8M
appropriated in
FY26

\$27.6M
appropriated
FY22-FY26



Performance

FY25 performance measure	Benchmark	FY24 performance
DLA-20 ¹	Establish by FY27 (FY24 target 35%)	25 CSBs met target (adult)

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27
Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Service members, veterans, and families services

Purpose

The service members, veterans, and families (SMVF) service category is intended to improve access to behavioral health services for:

- Members of the armed forces located 50 miles or more from a military treatment facility,
- Veterans located 40 miles or more from a Veterans Health Administration medical facility, and
- Family members of members of the armed forces or veterans

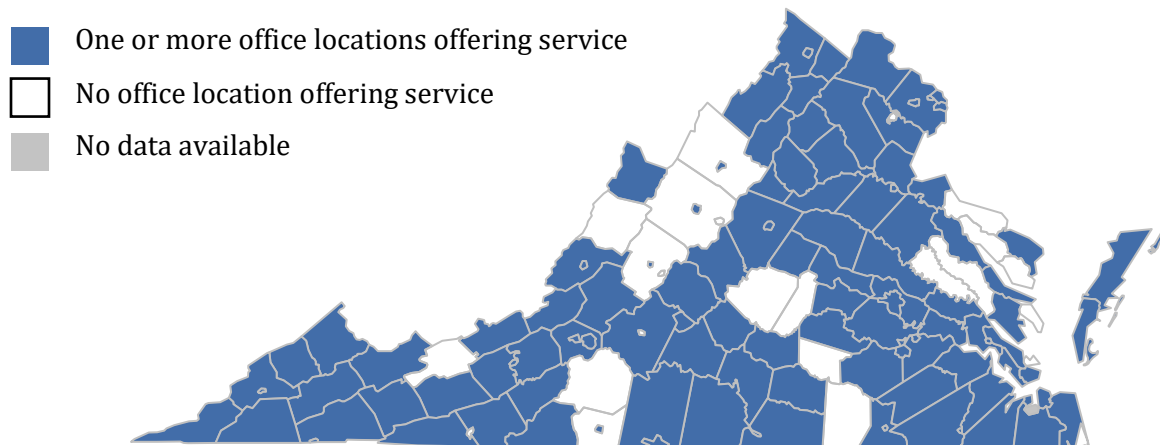
\$4.2M
appropriated in
FY26

\$20.0M
appropriated
FY22-FY26

Access

Exhibit B-6

SMVF services are available at office locations in 110 (83 percent of) localities



Performance

2025 performance measure	Benchmark	FY24 performance
Military/veterans cultural competency training	95%	15 CSBs met benchmark
Columbia suicide screening	86%	14 CSBs met benchmark

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Psychiatric rehabilitation

Purpose

The psychiatric rehabilitation service category is intended to help individuals develop independent living skills and to enhance social and interpersonal skills, family support, and education and vocational opportunities for individuals with behavioral health needs.

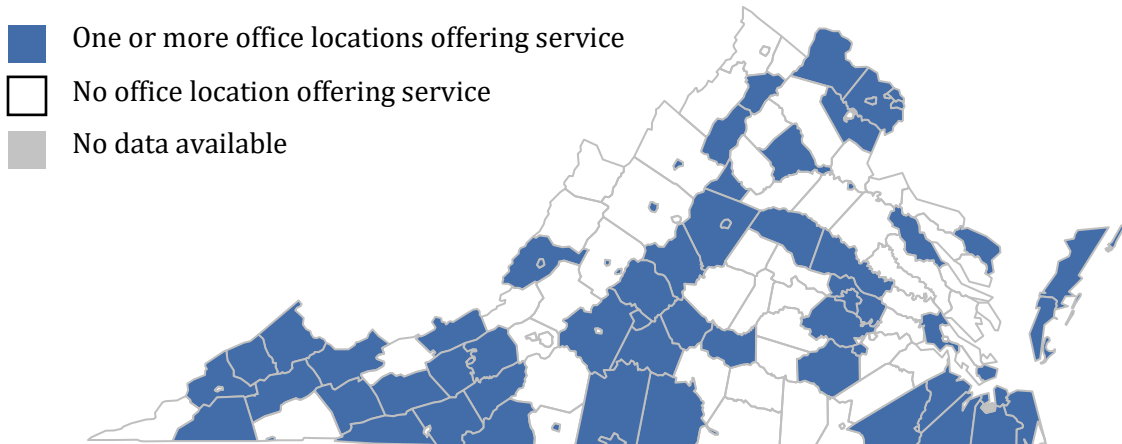
\$4.0M
appropriated in
FY26

\$14.0M
appropriated
FY23-FY26

Access

Exhibit B-7

Psychiatric rehabilitation is available at office locations in 69 (52 percent of) localities



Performance

2025 performance measure	Benchmark	FY24 performance
DLA-20 ¹	Establish by FY27 (FY24 target 35%)	25 CSBs met target (adult)

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Care coordination

Purpose

The care coordination service category is intended to improve outcomes of individuals with behavioral health service needs by organizing and individual's care to achieve safe, more appropriate and effective care.

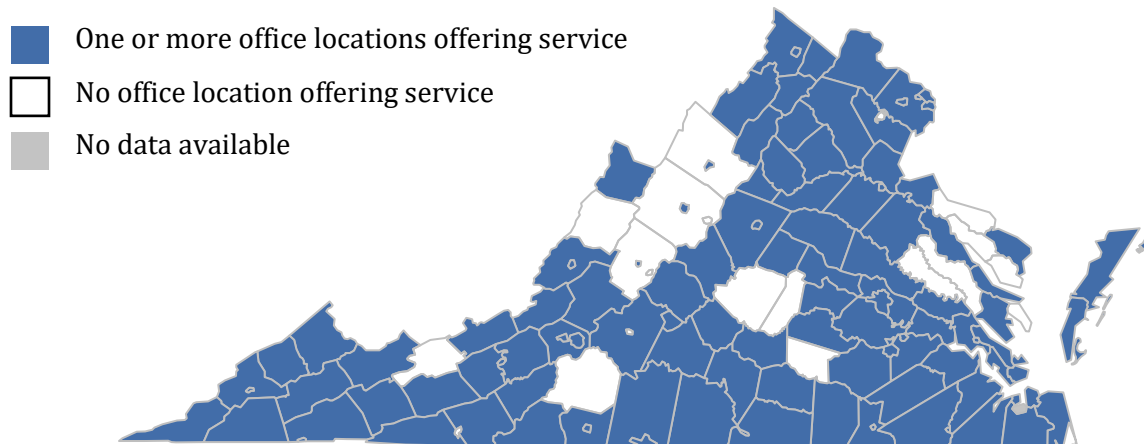
\$6.8M
appropriated in
FY26

\$26.7M
appropriated
FY23-FY26

Access

Exhibit B-8

Care coordination is available at office locations in 113 (85 percent of) localities



Performance

2025 performance measure	Benchmark	FY24 performance
DLA-20 ¹	Establish by FY27 (FY24 target 35%)	25 CSBs met target (adult)

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

Case management

Purpose

The case management service category is intended to assist and support individuals in developing their skills to gain access to needed mental health, behavioral health, housing, employment, social, education, and other services essential to meeting basic human needs by linking individuals to basic community resources and monitoring overall service delivery.

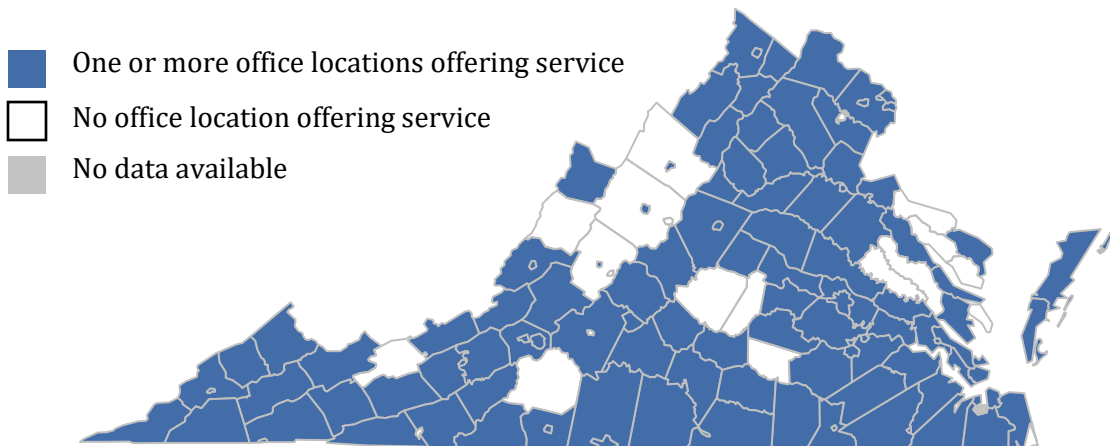
\$4.3M
appropriated in
FY26

\$15.8M
appropriated
FY23-FY26

Access

Exhibit B-9

Case management is available at office locations in 113 (85 percent of) localities



Performance

2025 performance measure	Benchmark	FY24 performance
DLA-20 ¹	Establish by FY27 (FY24 target 35%)	25 CSBs met target (adult)

¹DLA-20 will be replaced by WHO-DAS 2.0 short version in FY27

Source: BHC staff analysis of 2018-2024 DBHDS annual reports on STEP-VA, FY24-25 CSB performance contract, 2025 BHC survey of CSBs, and CSB performance data collected by DBHDS (FY18-FY25)

