



COMMONWEALTH of VIRGINIA

DARYL WASHINGTON, LCSW
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

October 21, 2026

The Honorable Barbara A. Favola
Chair, Joint Commission on Health Care
PO Box 687
Arlington, VA 22216

Dear Chairwoman Favola:

DBHDS shares JCHC's goal of ensuring every person leaving Hiram Davis Medical Center (HDMC) receives safe, appropriate care, and Virginians with similarly complex needs have a dependable safety net. Our September 21 letter committed to individualized planning with patients, families and guardians; verification of care and supports before each move; at least one year of transition monitoring, supported by Community Care Navigators; continued state-operated nursing capacity; specialized community options; staff employment support; and annual reporting on outcomes and resources. Following last month's meeting, JCHC requested specific budget language and additional detail about the proposed four- to six-bed home. This letter presents DBHDS' recommended approach in response to that feedback, clarifies the care models under consideration and recommends a revised closure schedule. The commitment proposal has not been reviewed by the Governor or received Administration approval at this time. Our commitments to individualized planning, safe transitions, and monitoring remain in place. The proposed funding and capacity are subject to the approvals described below.

1. A realistic transition schedule with continued urgency

Timeline change – As the Closure Plan review and the funding decisions have extended into the current budget cycle, DBHDS recommends **adjusting the closure date to June 30, 2028**. These additional months will ensure sufficient time to work with families to complete individualized planning, develop receiving providers, recruit and train staff, and verify readiness before each move. No patient will move before the receiving setting can provide the care and supports that person requires.

Building conditions – At the same time, the building's condition makes timely action essential. On October 3, 2026, another chiller malfunction and related electrical concerns caused temperatures in some bedrooms to reach 82 degrees. The malfunctions were repaired, but recurring failures show that repairs are not resolving the underlying deterioration. DBHDS has serious concerns about the building's continued reliability. Although the extended transition schedule is necessary, HDMC's aging infrastructure continues to pose significant risks, and

DBHDS cannot assure that the facility can remain safely operational through the revised closure date without a major system failure requiring evacuation.

Closure savings – With operations ending by June 30, 2028, no closure-related savings would be available for reinvestment earlier than FY 2029, starting July 1, 2028, after accounting for continuing services, closeout costs, and employee-related obligations. DBHDS will work with DPB to verify net savings before proposing their use.

2. A plan for future reinvestment with clear accountability

In response to JCHC’s feedback, DBHDS recommends developing a plan to use funds made available by HDMC’s closure to support individuals with chronic and complex medical needs. The agency will work with DPB and HHR during fall 2027 to identify net savings, service needs and specific uses for consideration in the Governor’s proposed FY 2029–FY 2030 budget and the 2028 General Assembly Session. A recurring appropriation or other funding mechanism would be considered through that process; this letter does not propose a current earmark of future savings.

Funding source	Recommended purpose
FY 2028 transitions	Identify costs and necessary transfers for current HDMC residents moving to other settings, using existing appropriations and applicable coverage.
Fall 2027 planning for FY 2029	Develop a specific reinvestment plan for verified net closure savings to support individuals with chronic and complex medical needs.

The reinvestment plan will identify the population to be served, assessed needs, existing Medicaid and other coverage, proposed uses and costs, and reporting measures. Any funding proposal will require the Governor’s consideration and action through the General Assembly’s budget process. DBHDS intends for the plan to address individuals receiving permanent or short-term services and future individuals with similarly complex needs who would otherwise have required HDMC services. People transitioning from HDMC would be the first priority. The plan will identify needs not otherwise payable by Medicaid, Medicare or other insurance and recommend reporting on expenditures, individuals served, services and capacity supported, and outcomes.

Session	Action requested
2027 Session	Seek approval of closure and the revised date, with necessary legislative authority, and propose FY 2028 transfers for continuing services and current residents’ care. All proposals remain subject to executive review and approval.
2028 Session	Present a specific reinvestment proposal developed in fall 2027 for consideration in the FY 2029–FY 2030 budget, based on verified net savings, service needs and existing coverage.

DBHDS commitments requiring new or redirected funding are contingent on the necessary appropriations and authority advanced by the money committees and approved through the General Assembly’s budget process and the Governor’s action. A JCHC recommendation can carry the Commission’s requested service protections, planning priorities and reporting expectations forward for consideration. It does not establish a funding amount, authorize expenditures or constitute executive branch approval.

3. Additional capacity and Behavioral Health and Developmental Services Trust Fund uses require further decisions

Use of the Trust Fund for group homes or other capacity remains under consideration by the Administration. DBHDS is therefore not presenting a Trust Fund appropriation or capital allocation as an agreed budget action for the 2027 Session.

DBHDS will continue to assess individual needs and options for capacity with HHR and DPB. Any proposal will identify the specific purpose, cost, funding source and spending authority required. Necessary renovations must continue while HDMC is occupied. Consistent with DPB's feedback, proposed Trust Fund spending for group homes and other development or transition reserves is omitted from the current list of budget actions. These items may be presented separately for the Governor's consideration if further review supports a specific request.

4. Continuing services that must remain funded

If closure is approved, the FY 2028 budget must account for continuing services and the costs of care for HDMC residents moving to other settings. Current estimates include approximately \$6.14 million annually for 36 positions and shared services at Central State Hospital, \$143,000 for a nurse educator at Southeastern Virginia Training Center (SEVTC), \$926,500 for a Medicaid General Fund long-term-care transfer, and \$590,000 for people whose services are not covered by Medicaid. These are DBHDS planning estimates, subject to DPB review and the Governor's budget decisions. DBHDS will reconcile existing appropriations and Medicaid coverage to identify necessary FY 2028 transfers, avoid counting the same dollars twice and preserve needed services. Continuing costs in FY 2029 and beyond will be accounted for before net savings and any reinvestment proposal are finalized. The small-home operating estimates in Appendix B are total program costs and are not additional transfer amounts. Any home proposal must identify Medicaid reimbursement, the state share and any uncovered costs, and reconcile those amounts with the transfers above before determining whether additional funding is needed.

5. Distinct care options designed around individual needs

DBHDS is evaluating at least one four- to six-bed enhanced home with a Community Services Board partner. Development, funding and any second home remain subject to demonstrated need and the Governor's consideration. The options include an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or a specialized mental health home. The two proposed community models serve different populations and cannot be combined in one home. Neither would be a skilled nursing facility (SNF). SEVTC is the state-operated skilled nursing option being developed and will meet all applicable state and federal requirements before operating in that capacity.

Option	People served and level of care
Enhanced ICF/IID home Four to six beds	People with I/DD and complex medical needs who require an intermediate care facility level of care; active treatment and on-site nursing appropriate to that model. Not skilled nursing certified.
Specialized mental health home 4-6 beds	People with serious mental illness, behavioral needs and significant medical conditions; enhanced residential supports and 24-hour on-site nursing.
SEVTC skilled nursing capacity two 5-bed homes	State-operated skilled nursing care for eligible people with ID; renovations, certification and operation must satisfy applicable state and federal skilled nursing requirements.

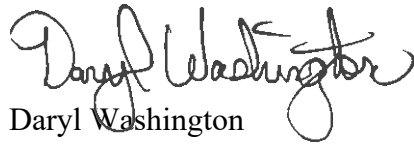
The small-home estimate presented in September is approximately \$2 million to renovate an existing structure. New construction is estimated at \$4.3 million, excluding land. These are preliminary planning estimates provided in response to JCHC's request, not approved expenditures or commitments to use the Trust Fund. The construction methodology, staffing, operating costs and timelines described in Appendix B remain planning assumptions subject to further review and approval. An enhanced home with on-site nursing is a residential option, not a SNF-certified nursing facility. These capital estimates are for one home and exclude ongoing operations. At six occupied beds, annual operating planning assumptions are \$1.8 million for an ICF/IID or \$1.85 million for a specialized mental health home. Developing both models would require separate capital and operating budgets; neither amount is an approved appropriation.

6. Continued accountability for each person

Each placement will be guided by clinical needs, individual preferences and family or guardian input. DBHDS will verify staffing, training, medications, equipment and necessary clinical services before a move; monitor outcomes for at least one year; and address concerns through case conferences, provider assistance and corrective action when needed. If a placement is not a safe and appropriate fit, DBHDS will identify another option. We will report on both current patients' outcomes and the availability of services for future individuals with comparable needs.

Thank you again for your support of the individuals, families, and staff at HDMC.

Sincerely,



Daryl Washington
Commissioner

Enclosures:

Appendix A Recommended Budget Actions Subject to Executive Review and Approval

Appendix B Small Home Planning and Cost Assumptions Subject to Further Review and Approval

Appendix A

Recommended Budget Actions Subject to Executive Review and Approval

Proposed Budget Language by General Assembly Session

Subject to Executive Review and Approval

DBHDS proposes the following language to support HDMC closure, authorize approved Trust Fund expenditures and address ongoing services. Trust Fund amounts and uses remain subject to approval. Reinvestment of closure savings would begin no earlier than FY 2029.

GA session	Proposed language
2027 Trust Fund spending authority	Notwithstanding subsection B of § 37.2-319 of the Code of Virginia, out of this appropriation, \$X.X the first year and \$X.X the second year from the Behavioral Health and Developmental Services Trust Fund shall be provided to the Department of Behavioral Health and Developmental Services for [approved project and specified one-time costs] supporting individuals transitioning from Hiram Davis Medical Center. The Department is authorized to expend these funds solely for the specified purposes. Any unexpended appropriation at the close of the first year shall be reappropriated in the second year for the same purposes.
2028 Ongoing services FY 2029–FY 2030	X.1. Out of this appropriation, \$X.X of general fund shall be provided to the Department of Behavioral Health and Developmental Services for medically necessary services and supports for individuals with developmental disabilities who have complex medical needs or are medically frail. Funds shall cover only costs not covered or otherwise payable by Medicaid, Medicare, or other insurance.

Note: Necessary FY 2028 transfers for continuing services and current residents' care would be reflected in the affected agencies' appropriation schedules.

Appendix B

Small Home Planning and Cost Assumptions Subject to Further Review and Approval

Plan for 4 to 6-Bed Home

DBHDS presented an option to JCHC at the September 23 meeting to renovate an existing structure for a four- to six-bed enhanced home at an estimated one-time cost of \$2 million. The home could serve either individuals with intellectual or developmental disabilities who require an intermediate care facility level of care or individuals with serious mental illness who require enhanced medical supports. As described in the letter, closure savings would not be available before FY 2029. Any development before then would require a separately identified and approved funding source and spending authority. Trust Fund use remains subject to Administration review and appropriation.

New construction is estimated at approximately \$4.3 million per home (\$4.329 million under the methodology below), excluding land. The concept includes up to 5,000 square feet and potential expansion to six to eight beds, subject to design and approval. The operating estimates below model a 4 to 6-bed home and do not establish operating costs for an expanded eight-bed home.

The new-construction estimate uses \$666 per square foot based on the [Virginia Building Construction Cost Database](#), with soft costs estimated at 30% of construction costs. The \$2 million renovation estimate is a separate preliminary estimate; its scope and cost basis require confirmation for the selected property.

Methodology

- 5,000 square feet * \$666 per square foot = \$3.33 million for construction
- 30% * \$3.33 million = \$999,000 for soft costs
- \$3.33 million + \$999,000 = \$4.329 million total new-construction cost per home, excluding land.

These cost estimates do not include pricing for land acquisition. This cost would be specific to the desired location and local markets. In addition, the timeline for completion of a single home is as follows, dependent upon whether such home is a state or community build. Capital costs are separate from annual staffing and other operating costs. If both models are developed, each home will require its own capital budget and recurring operating funding.

	Renovation of Existing Structure	New Construction
State Build	12 months	16 months
Community Build	9 months	12 months

Target Populations

The following describes two potential residential models: (1) an ICF/IID for individuals with intellectual or developmental disabilities and complex medical needs, or (2) a specialized group home for individuals with serious mental illness and complex medical needs. These models would require separate homes if both populations are to be served. Either model could accommodate four to six residents, but neither would provide the skilled nursing facility certification planned for the 10 renovated beds at SEVTC.

	4-6 Bed ICF/IID	Specialized MH Home
Brief description	3 DSPs on duty each shift, 24/7. Approximately 12.6 FTE before additional leave and relief coverage; final relief staffing requires confirmation.	4–6 bed state-funded specialty residential setting for people with serious mental illness related behavioral needs and significant medical conditions requiring 24-hour on-site nursing.
Direct-care staffing	Day: RN on site; evening and overnight: LPN on site. Approximately 4.2 nursing FTE before additional leave and relief coverage. RN supervision and relief costs must be confirmed within the staffing budget.	2 behavioral/direct-care staff on duty 24/7; approximately 9–10 FTE including relief coverage.
Nursing	1 Residential Manager; ~0.5 Program/Clinical Director; QIDP/clinical, dietary and medical consultation.	1 nurse on site 24/7; approximately 5 FTE including relief coverage.
Leadership/clinical	Approximately 19–21 FTE, subject to confirmation of relief coverage and clinical oversight.	1 Residential Manager; 1 Program/Clinical Director; behavioral/clinical professional

	4-6 Bed ICF/IID	Specialized MH Home
		plus psychiatry, medical and pharmacy consultation.
Estimated total staffing	3 DSPs on duty each shift, 24/7. Approximately 12.6 FTE before additional leave and relief coverage; final relief staffing requires confirmation.	Approximately 17–19 FTE
Estimated annual staffing cost	\$1.45M–\$1.65M	\$1.45–\$1.65 million
Other annual operating costs	\$250K–\$300K	\$250,000–\$350,000
Estimated total annual cost	\$1.70M–\$1.95M; annual planning assumption: \$1.80M.	\$1.7–\$2.0 million
Primary funding	Medicaid ICF/IID reimbursement assumed, subject to confirmation. The total program estimate includes both federal and state funding; the state share and any nonreimbursable or supplemental costs require separate identification.	100% state/General Fund support assumed.

Planning Per-Diem Comparison

ICF/IID reimbursement note. The figures below are calculated total program costs per resident day, not approved Medicaid payment rates or net state funding requirements. Medicaid reimbursement remains subject to allowable costs and applicable limits. All columns use the same annual planning assumptions: \$1.8 million for one ICF/IID home and \$1.85 million for one specialized mental health home, divided by occupied beds and 365 days. Actual costs may vary with home size and staffing.

Model	4 occupied beds	5 occupied beds	6 occupied beds
ICF/IID total program cost	\$1,233	\$986	\$822
Specialized MH home state-funded cost	\$1,267	\$1,014	\$845

Six-bed planning summary. For initial budgeting, assume approximately \$1.8 million annually for the ICF/IID, equivalent to \$300,000 per resident annually or approximately \$822 per resident day at full occupancy. This assumes Medicaid reimbursement sufficient to support the modeled program, which remains to be confirmed. For the specialized MH home, assume approximately \$1.85 million annually in state funds, equivalent to approximately \$845 per resident day at full occupancy. If both homes are developed, the combined annual planning estimate is \$3.65 million in total program costs, before distinguishing Medicaid reimbursement from the net state funding requirement. This is separate from one-time capital costs and is not automatically additional to the continuing-service transfers in the letter.

Planning assumption: These figures are preliminary program-development estimates. Final costs will depend on acuity, wage levels, benefits, facility costs, required staffing ratios, Medicaid allowable-cost treatment, and actual occupancy. The ICF/IID staffing totals and relief assumptions must be reconciled before the operating budget is finalized. The annual cost ranges remain preliminary; this revision does not establish a new staffing budget.