**Question and Answer from RFA Pre-Application Meetings for Regions 1 and 3**

**Q: Am I right to assume that we would not be able to use it to expand SUD OP for kids unless the proposal included SUD detox and Residential?**

A: The goal for this proposal is to expand or enhance regional infrastructure/capacity to serve youth with substance use and co-occurring disorders.  The primary focus is on ASAM levels of care 2.0 and up (which includes IOP, PHP and residential programs).  This is because the data from our needs assessment indicated the biggest gap in services at the higher levels of care.  However, the proposal does not have to be a detox or residential program.

We are prioritizing ASAM levels 2.0 and up in the application review process.  And we do understand the need for a full continuum of adolescent substance use services-our long-term goal is to create a system of care that includes outpatient through residential detox.  What DBHDS would encourage is that the CSB look to other community partners on this continuum and to put together a proposal that would include outpatient and/or a referral process to a higher level of care if clinically indicated.  A CSB can act as a step down from another level of care.  We welcome a creative approach to this as our overall goal is to expand substance use services to adolescents.  DBHDS wants the proposal to be reflective of the communities’ largest need and to be based on local data or a needs assessment and to have other community support (or regionally with other CSB's).

**Q: The RFA mentions ‘enhance and expand’, our CSB has youth mental health services but lacks in adolescent substance use services, does this count as enhanced or expansion?**

A: Yes, this is part of the larger continuum of care, recognizing that some adolescents receiving mental health treatment will be better served in targeted substance use treatment if the need exists and understand that adolescents that reduce their substance use may need mental health treatment if the substance was an effort to self-medicate. There is a large co-morbidity rate for SU and MH diagnoses for adolescents. Integrating substance use treatment services within residential settings would be appropriate.

**Q: Will we know what to expect from data collection before the project starts?**

A: A standard data tool will be provided upon award and execution of the Exhibit D. There will be two ways to measure success which include utilization and implementation.

**Q: What about regional projects?**

A: Regional collaboration is strongly encouraged and there can be multiple submissions if there are multiple regional projects (due to geographic needs). Details on regional program operating principles can be found in the Core Services Taxonomy document, Appendix E. [Revised Core Services Taxonomy 6 (virginia.gov)](https://www.dbhds.virginia.gov/assets/doc/BH/oss/2010coreservicestaxonomy72v2.pdf)

**Q: The proposal speaks to IOP and above, do we want to include ASAM Level 1 information as well since we are looking at the continuum?**

A: Yes, part of the RFA is looking at the continuum of care and where referral sources and care coordination efforts can be made. Speaking to EBPs at the ASAM Level 1 available in your locality and how this supports the substance use continuum of care can be beneficial in your proposal.

**Q: Can we receive this funding and bill Medicaid?**

A: Billing Medicaid can be part of the plan for sustainability. Generally, federal funds can't be used to pay for the exact same cost or an activity already paid for from another funding source...referred to as double-dipping or a duplication of benefits. However, if one federal fund source doesn't provide enough funding for the entire amount of an activity, funds can be applied from another federal source, so long as it's not in excess of the total amount needed for the activity.

**Q: Would adding to a current children’s CSU (mental health focused) a level 3.7 unit, qualify as expanding an existing program?**

A: This would be considered expanding on existing infrastructure and would be allowable if the program meets the intention of expansion of substance use services at the appropriate ASAM level of care that matches the treatment setting.

**Q: Would it be allowable to have a dedicated provider for this service that is in-house (vs. telehealth)?**

A: Yes, service provision would need to follow the current licensing regulations and requirements under the ARTS benefit for Medicaid members. Please note there are final ASAM licensing regulations that were just adopted. See link here: [Final-ASAM-Memo.pdf (virginia.gov)](https://dbhds.virginia.gov/wp-content/uploads/2023/02/Final-ASAM-Memo.pdf)

**Q: Would you accept other services than what is listed in the proposal?**

A: The services that DBHDS is focused on funding under the regional funding Youth and Family Hope Start Up Funding, are **Community and hospital based** **Partial Hospitalization Program** (PHP/ASAM Level 2.5), **Ambulatory Withdrawal Management** (levels 1 and 2), **Intermediate Care Facilities for under 21-year-olds** (ICF-A/ASAM Level 3.7 and 3.7-WM), and **Inpatient Withdrawal Management** (Level 4.0). However, DBHDS would like to see plans for step-down/discharge services as part of the system of care under this proposal even if not primarily funded under this project.

**Q: Is this the full amount listed what is available?**

A: Yes, the amount listed on the RFA is what is current allocated to this project. Please note, this RFA is for two regions and DBHDS intends to award more than one proposal. Given the size of regions 1 and 3, DBHDS would welcome more than one proposal per region.

**Q: Is the application date, April 3rd?**

Yes: That is correct. March 3rd at 5pm is the last date for questions to be submitted. After that, all questions and answers will be posted on our agency website.

**Q: Do the plans submitted have to be regional plans or would DBHDS consider funding a single board or a smaller group of boards (sub-regional)?**

A: DBHDS has limited funds for this project which is why a regional approach was suggested. However, it is not a requirement of this project to do a regional plan. An individual CSB plan could be submitted but would be reviewed against the criteria that would most closely align with expanding capacity where it is most needed. DBHDS is encouraging (especially in larger more geographically disperse regions) to consider a sub-regional approach and to partner with other CSB’s and private providers around referrals and appropriate levels of care for step down. At a minimum, DBHDS recommends reviewing this proposal with your region to determine the best collaboration to enhance community-based levels of care for adolescent substance use treatment services.