SB202 MSO Community Action Plan

REQUEST FOR APPLICATION

SIGNAL BEHAVIORAL HEALTH NETWORK
6130 GREENWOOD PLAZA BLVD, #150, GREENWOOD VILLAGE, CO 80111

MAT Expansion and Education RFA (S1-1718-MAT)

1 Overview and Timeline

1.1 About Signal Behavioral Health Network

Signal Behavioral Health Network (Signal), is one of Colorado's Managed Service Organizations. Signal is responsible for providing a continuum of substance use disorder (SUD) services in three regions on behalf of the State of Colorado. Additionally, Signal seeks to ensure a consistent level of quality and compliance with State and Federal requirements relating to services offered. Signal may choose to deliver these services by subcontracting with local providers who demonstrate competency, compliance with quality standards, and positive outcomes.

The regional map for Managed Service Organizations is known as Sub-State Planning Areas (SSPAs). There are seven SSPAs in Colorado:

- SSPA 1: Northeast Colorado (Signal)
- SSPA 2: Metro Denver (Signal)
- SSPA 3: Colorado Springs Area
- SSPA 4: Southeastern Colorado including San Luis Valley (Signal)
- SSPA 5: Northern Western Slope
- SSPA 6: Southern Western Slope
- SSPA 7: Boulder

Signal is responsible for providing services in three of these seven regions (Northeast Colorado, Metro Denver, and Southeastern Colorado including San Luis Valley).

1.2 About the Increasing Access to Effective Substance Use Disorder Services Act (SB16-202)

During the 2016 Colorado Legislative Session, the Increasing Access to Effective Substance Use Disorder Services Act was passed, directing and empowering Colorado's Substance Use Disorder Managed Service Organizations to perform several tasks:

1) Conduct a statewide needs assessment reviewing and identifying gaps in SUD services, including issues with capacity, access, and sustainability
2) Develop and refine community action plans, with intentions around addressing as many areas of priority as possible
3) Direct coordination, strategy, and funding towards as many of these areas as possible

The needs assessment is a previously completed report, outlining community feedback, gleaned from interviews, stakeholder meetings, surveys, and previous research and needs assessments. Much of this report is based on that needs assessment. It can be found by visiting:

http://www.cbhc.org/wp-content/uploads/2017/02/SB202-SUD-final-1.pdf

Readers of this request for application are encouraged to review that report in its entirety to allow for context and support for the initiatives targeted.

1.3 RFA Community Action Plan Priority Area

Medication-Assisted Treatment (MAT) Expansion and Education

1.4 Objective

Signal's objective is to expand medication assisted treatment, particularly with opioid replacement drugs such as buprenorphine, and relapse prevention drugs such as extended-release naltrexone. Additionally, expansion of the use in primary care clinics of oral and injectable extended-release naltrexone for persons in treatment for opioid and alcohol disorders is desireable.

1.5 Location

The services outlined in this document should be located in any or all of the following Colorado counties: Weld, Larimer, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, or Cheyenne.

1.6 Submission Deadline and Instructions

Providers interested in offering this service should submit their proposal in Word format. The associated budget should use OBH's capacity budget protocol in Excel format. Proposals should be submitted via email to the below email address. Signal will acknowledge receipt of each proposal. If no acknowledgement occurs, respondents to this request for proposal should resubmit.

proposals@signalbhn.org

The deadline for submission is no later than 6/15/2017. Signal will begin considering requests for funding as soon as we have received those applications and will begin funding as soon as possible.

1.7 Budget

Providers should include a budget for offering this service in one or more of the locations, using the State Office of Behavioral Health (OBH) capacity budget protocol worksheet (Appendix A). Signal recognizes that this funding is only a part of the support necessary to provide the service. Additional funds are required via Medicaid, other governmental sources, client fees, grants, local hospital support, and other sources. The OBH capacity protocol provides a mechanism to capture all funding sources relative to total expenses. Signal's funding can be used to cover any shortfall that may exist. Details of the protocol are available upon request.

It is important to note that there are two forms a service expansion may take:

1) **Increase of clients serviced:** In other words, an existing program could be expanded to serve more clients.
2) **Expansion of facility:** A new or expanded facility may be required to serve more clients. Effectively, these are one-time costs associated with the expansion.

1.8 TERM OF AGREEMENT

Signal seeks provider agencies who will offer or deploy the services outlined beginning as soon as possible, with optional renewals of the contract in subsequent years. This funding is available for the State Fiscal Year of July 1, 2017 through June 30, 2018.

2 REQUESTED SERVICES

The objective of the utilization of these funds is to provide access to effective substance use disorder services across the state of Colorado, in the regions identified. The objective is to provide increased access to effective substance use disorder medication assisted treatment (MAT) services across the state of Colorado.

2.1 OVERVIEW OF SERVICES

The requirement is to establish and/or expand, and maintain access to, quality care with appropriate medication assisted substance use disorder (SUD) treatment.

Substance-use treatment services need to be operated within a continuum of substance-use care, and transitions actively managed along that continuum to achieve positive outcomes. This continuum of care should include detoxification, outreach, assessment, access to multiple levels of outpatient services, residential treatment, community-based case management, and continuing care. It is critical that connection to, and movement through, this continuum of community-based services be flexible. There need to be relationships between SUD treatment and continuing care provided in a variety of settings, including primary care and other medical settings. It is vital that comprehensive community-based case management services be directly connected to SUD treatment services. Medication assisted treatment of SUD is essential to improve treatment outcomes, and improve individual overall health outcomes.

2.2 BACKGROUND

Medication-assisted treatment (MAT) utilizes a combination of behavioral therapy and medication to treat substance use disorders. MAT is most commonly used to treat opioid addiction as part of an opioid treatment program (OTP) or to treat alcohol dependency. Medications can be utilized as part of detoxification to assist with medical symptoms and cravings, or integrated into a longer-term treatment plan for patients and combined with additional treatment modalities.[1] Generally, medications are classified based on how they target the brain's receptor sites. *Agonists*, which either fully or partially mimic a substance's effect by activating corresponding receptors in the brain, are used in replacement therapies to suppress withdrawal symptoms and reduce cravings. *Antagonists*, which attach to receptors (but do not activate them) and inhibit the reception of other drugs, can be prescribed as a maintenance medication that eliminates the rewards of substance use and thus help prevent relapse.[2,3] Safety and effectiveness are primary considerations for administration of MAT, along with patient characteristics such as substance use history and treatment goals.[3]

2.2.1 Established Support

- MAT specifically for opioid addiction has been demonstrated to extend engagement in treatment as well as to reduce drug use, drug-related mortality, and criminal behavior.[4,5]

- While several medications (e.g., methadone, buprenorphine, naltrexone, and extended-release naltrexone) are widely utilized in MAT for opioid addiction and have strong evidence for safety and efficacy, with methadone in use the longest.[5,6]
- In addition to reducing drug use and related mortality, criminal behavior, and increasing patient retention, methadone maintenance has been shown to:
  - Reduce additional drug-related health issues such as Hepatitis, HIV, and cellulitis;
  - Increase functioning in employment, family and social aspects of patient lives; and
  - Increase compliance with additional therapies such as those related to HIV/AIDS. [5]

2.3 DELIVERY OF MEDICATION-ASSISTED TREATMENT

There are multiple possible ways to access and deliver medications essential to SUD treatment. MAT should be available as a part of the delivery of detox (withdrawal management), outpatient, residential, continuing care, recovery support, and primary medical care. Medications may be provided outside SUD treatment settings.

The essential requirement is that medication be part of treatment, and treatment part of medication. Responding providers should indicate how both sides of MAT will be supported and delivered.

2.3.1 Medication Assisted Treatment (MAT)

Specific medications to be integrated into care:

- methadone
- buprenorphine
- extended-release naltrexone

Signal is interested in innovative and creative solutions to expand medication assisted treatment throughout each regional continuum of care. Signal will consider all proposals. Possible MAT integration services include:

- SUD specialty providers and mental health centers: outpatient, residential, detoxification, Opioid Treatment Programs (OTP)
- Hospital emergency departments, including initial induction, engagement with specialty provider
- Jails and prisons prior to release into the community
- Collaboration between primary care clinics providing medication, coupled with SUD specialty clinics providing treatment
- Office-Based Opioid Treatment (OBOT);
- SUD specialty clinics providing the treatment portion of MAT for individuals in a variety of medical settings

Examples of models for enhancing access and expertise:

- Extension for Community Healthcare Outcomes (ECHO)
- Office-Based Opioid Treatment (OBOT) modified hub & spoke
- Expansion of buprenorphine prescribing to Nurse Practitioners and Physician Assistants

2.4 KEY ELEMENTS

- **MAT is most effective when utilized as part of a comprehensive treatment plan** that addresses social and behavioral problems as well as any co-occurring mental health disorders.[7]

- **Appropriate infrastructure is necessary to conduct MAT** and includes medication delivery, identifying funding and complying with regulatory standards, certification, and training requirements for staff and physicians.[3]
- **Office-based opioid therapy is an option for MAT** that studies have shown to be both safe and efficacious. For qualified patients who show a history of stability, prescriptions for medications such as buprenorphine can be ordered by a specially qualified physician, nurse practitioner, or physician's assistant and taken at home.[5,8,9]
- **MAT is underused for alcohol use disorders**, despite the availability of effective medications that can be administered in an outpatient setting. Medications such as extended release injectable naltrexone and acamprosate are shown to be efficacious for helping patients maintain abstinence.[3]
- **Funding sources for MAT and state-level Medicaid authorization requirements** can have great impact on patient access to services.[10]
- **It is important to consider current public and service provider attitudes toward MAT** in specific areas to ensure that implementation will be supported by service recipients as well as providers.[3,11]
- **Medications utilized in MAT should be individualized** in terms of patient goals for treatment and preferences.[7]

2.4.1 Signal Credentialing

If not currently a Signal provider, then the provider must complete the Signal credentialing packet, included in Appendix B (with exception of the OBH licensing process which may begin concurrently following selection as a provider offering these services). The required information should be included in the submission.

3 RESPONSE FORMAT

Respondents to this proposal request should include the following elements:

1. When referencing this RFA, use RFA **#S1-1718-MAT**
2. Business Proposal, indicating compliance, understanding, and restatement of all provisions and requirements listed in section 2.
3. Signal Credentialing: except for the OBH license, all documents and items required in the Signal Credentialing list in Appendix B
4. This RFA is supported using Capacity as the reimbursement. Respondent should include a budget narrative, as well as:
    a. If this RFA indicates fee-for-service reimbursement, then the provider should submit requested rates.
    b. If capacity funded, then provider should submit an OBH capacity (see Appendix A) budget for SFY1718
5. The goal for increased number of indigent clients served. This funding is intended to serve indigent clients. Indigent clients are defined as individuals whose household income is at or below 300% Federal Poverty Level (FPL).
6. The following representatives should be identified. Include name, title, email address, and phone number for each.
    a. Proposal lead
    b. Chief Executive Officer, Executive Director, or equivalent.

    c. Chief Financial Officer, or equivalent
    d. Clinical Director
7. A timeline, including
    a. Project start
    b. Intermediate milestones
    c. Service delivery start (if applicable)
8. Location (or multiple locations) that this proposal covers.

4 EVALUATION AND DECISION

Signal will review all proposals upon receipt (no later than 6/15/2017). Failure to provide a complete set of information requested in this document may result in exclusion from consideration.

Signal may seek clarifying information as necessary to make an informed decision either from the respondent provider or from other sources.

After selection of a provider or providers for these services, Signal will notify remaining respondents of the decision.

5 REFERENCES

1. Substance Abuse and Mental Health Services Administration (2017). *Medication Assisted Treatment*. Retrieved from https://www.samhsa.gov/medication-assisted-treatment
2. Network for the Improvement of Addiction Treatment (NIATx) at the University of Wisconsin–Madison and the Treatment Research Institute (TRI) in Philadelphia. (2010). *Getting Started with Medication-Assisted Treatment: With Lessons from Advancing Recovery*. Retrieved from http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf
3. Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism, Medication for the Treatment of Alcohol Use Disorder: A Brief Guide. HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
4. National Institute on Drug Abuse. (2012). *Medication-Assisted Treatment for Opioid Addiction*. Retrieved from https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
5. Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration.
6. Substance Abuse and Mental Health Services Administration. Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide. HHS Publication No. (SMA) 14-4892R. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
7. Center for Substance Abuse Treatment. (2005.I6). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration.
8. The Comprehensive Addiction and Recovery Act (CARA), S.524/H.R.953. (2016).
9. National Institute on Drug Abuse. (2012). *Principles of Effective Treatment.* In Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment
10. American Society of Addiction Medicine. (2013). *Availability without Accessibility? State Medicaid Coverage and Authorization Requirements for Opioid Dependence Medications.* In Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. Retrieved from http://www.integration.samhsa.gov/clinical-practice/mat/Advancing_Access_to_Addiction_Medications_-_Implications_for_Opioid_Addiction_Treatment.pdf.
11. Substance Abuse and Mental Health Services Administration, HRSA Center for Integrated Health Solutions. (2016). *Medication Assisted Treatment Implementation Checklist*. Retrieved from http://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Appendix A

OBH Capacity Budget Template

Provider Name:				
Program Name:				
Contract Period:				
		Budget	**YTD Actual**	**Variance**
	EXPENSES			
Personnel:				
	Clinical	-		
	Support	-		
	Kitchen	-		
	Operations	-		
	Other	-		
	Total Personnel	**-**		
Client Expenses:				
	Kitchen Supplies			
	Client Food			
	Client Transportation			
	Medications			
	Medical Supplies			
	Personal Hygiene Items			
	Laundry/Linens			
	Client Recreation			
	Purchased Services			
	Contractors			
	Other			
	Total Client Expenses	**-**		
Occupancy:				
	Janitor			
	Supplies			
	Utilities			
	Phone			
	Rent			
	Equipment Lease			
	Building Maintenance			
	Grounds Maintenance			
	Other			
	Total Occupancy	**-**		
Operating:				
	Insurance			
	Auto Expense			
	Staff Development			
	Employee Training			
	Travel & Lodging			
	Business Meals			
	Mileage			
	Computer Supplies/Equipment			
	Office Supplies			
	Postage			
	Printing			
	Dues, Fees & Licenses			
	Equipment & Furnishings			
	Renovation & Construction			
	Depreciation			
	Advertising			
	Public Relations			
	Legal			
	Audit			
	Consultants			
	Other			
	Total Operating	**-**		
Indirect:				
	Finance & Accounting			
	Contracting & Purchasing			
	IT System & Services			
	Legal			
	Human Resources			
	Total Indirect	**-**		
	Grand Total Expenses	**-**		
	Revenue Offsets			
Client Services:				
	Medicaid Fee for Service Cash			
	Medicaid Capitation Encounters *			
	OBH Indigent Encounters *			
	3rd Party Insurance Cash Receipts			
	Medicare Cash			
	Self-Pay			
	Cash from Other Sources			
	Total Client Service Cash	**-**		
** Encounters valued using the current year's fee for service schedule issued by OBH and not to exceed contract amount*				
Contracts and Grants:				
	MSO Revenue (from other OBH contract budget lines)			
	Non-Governmental Contracts			
	Other State Revenue/Accrual			
	Local Funds/Accrual			
	Federal Grant Funds/Accrual			
	Public Support			
	Other Funds (Specify below)			
	Description			
	Description			
	Total Contracts and Grants	**-**		
	Grand Total Revenue Offsets	**-**		
Net Cost Invoiced**		**-**		
**Net Cost Invoice may not exceed the OBH Contract to exceed price for this capacity based contract exhibit or contract.				
Exempt Revenue Offsets				
Private Grant Funds				
Private support or donations				
In-kind donations				
Local Hospital funds				

Appendix B

Signal Credentialing

Signal Behavioral Health Network

Credentialing for Membership as a Signal Provider

CREDENTIALING DOCUMENTATION

Below is a listing of the documentation required for application as a credentialed provider with Signal Behavioral Health Network.

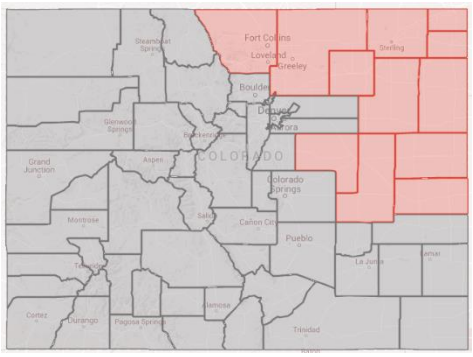
a) Copies of all current OBH licenses
b) Copies of any current licenses/certificates from any organization regulating any portion of the Provider's treatment services. These may include, but not limited to:
    - JCAHO/CARF/COA approvals, if applicable
    - Residential Child Care Facility license, if applicable
    - Residential Treatment Center license, if applicable
    - Drug Enforcement Administration Provider certification, if applicable
    - Drug Enforcement Administration Physician license(s), if applicable
    - Federal Drug Administration and Pharmacy Board registration, if applicable
c) Federal tax ID number
d) Certificate of general liability and professional liability insurance, professional automobile, and general office insurance. The professional liability policies shall have a minimum coverage limit of $1,000,000 per individual occurrence and $1,000,000 aggregate. Exceptions to these minimum coverage requirements will be considered on a case-by-case basis.
e) Certificate of worker's compensation insurance, if applicable
f) Certification of malpractice insurance for doctors/nurses, if applicable
g) Certification of Director's and Officer's Insurance, if applicable
h) Notification if insurance was ever denied or canceled and the reason(s) for any such denial or cancellation
i) Most recent list of the members of the Provider's Board of Directors, if applicable
j) List of current Provider clinical staff including credentials, CAC level, and date of hire. Credentials refer to any educational degrees, any professional licenses, and any type of teaching certificates.
k) Notification that all current clinical staff have been reviewed in the DORA database for any disciplinary actions and a description of the Provider's response to any disciplinary actions discovered
l) Notification of any investigation of the agency by any regulatory agency that resulted in any type of corrective action or change in status during the two years prior to submission of the credentialing packet. Regulatory agencies include, but are not limited to, OBH, DMH, JCAHO, and CARF.
m) Notification of compliance with all HIPAA regulations, if applicable
n) Notification of any Federal debarment
o) Copy of most recent financial audit and management letter
p) Copy of most recent agency approved budget
q) Number of pregnant women and injecting drug users served in the past 18-months

Appendix C

Signal Sub-State Planning Areas

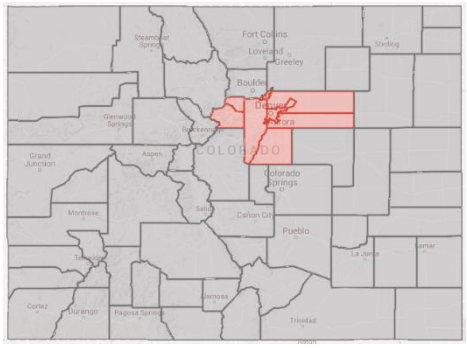
SSPA 1: Northeastern Colorado

- Cheyenne
- Kit Carson
- Larimer
- Lincoln
- Logan
- Morgan
- Phillips
- Sedgwick
- Washington
- Weld
- Yuma



SSPA 2: Denver Metro and Foothills

- Adams
- Arapahoe
- Broomfield
- Clear Creek
- Denver
- Douglas
- Gilpin
- Jefferson



SSPA 4: Southeastern Colorado & SLV

- Alamosa
- Baca
- Bent
- Conejos
- Costilla
- Crowley
- Huerfano
- Kiowa
- Las Animas
- Mineral
- Otero
- Prowers
- Pueblo
- Rio Grande
- Saguache