APPENDIX I

BENEFIT AND QUALIFICATIONS FORMS

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Assertive Community Treatment (ACT)

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Community based services and interventions provided by a multidisciplinary team. Team members must include physicians, nurses, vocational specialists, substance use disorder specialists, peer specialists, and community support specialists. When this service is provided to young adults on a transition age youth ACT team serving persons up to age 26, the team must include a family support specialist. Interventions include but are not limited to: specialized assessments and treatment planning; case management; crisis intervention; assistance in locating and maintaining safe, affordable housing; assistance with finding and maintaining employment and education; skills training to support daily living skills, self-care skills, and financial management; illness and symptoms management; substance use disorder treatment and supports; and supporting and facilitating access to necessary medical and social services.
Qualified provider: ACT teams approved by the Division of Behavioral Health (DBH).
Limitations: Limited to one (1) unit per day. The daily rate may be billed when the non-medical team members have a direct contact with the individual or direct contact with a collateral contact. If there are multiple direct contacts in a day from non-medical team members, the procedure code is only billed once. Psychiatric Diagnostic Evaluation, Medication Management, and Professional Consultation are billed outside of the daily ACT team rate. This service may only be provided by an organization with a mental health contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 1 per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements,

_____

if any:

Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: ACT teams must be approved by the Division of Behavioral Health

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: ACT team approved by Division of Behavioral Health
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Behavioral Health Assessment

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
This service consists of screening, eligibility determination, and behavioral health assessment. Eligibility determination requires the rendering of a waiver-eligible diagnosis by a licensed diagnostician or a physician/APN, and shall include at a minimum: presenting problem and referral source; brief history of previous psychiatric/substance use disorder treatment including type of admission; current medications; current mental health symptoms; current substance use/misuse; current medical conditions; diagnoses, including mental disorders, medical conditions and notation for psychosocial and contextual factors; functional assessment using a Department approved instrument; identification of urgent needs; initial treatment recommendations; initial treatment goals to meet immediate needs during the first 45 days of service; and signature and title of all service providers. The initial assessment shall be completed within 30 days of the date of completion of eligibility determination, and shall include the following: basic demographic information; presenting concerns; risk assessment; trauma history; mental health treatment history; mental status; substance use treatment history and current use; medication information; physical health summary; assessed needs – functional domains; risk taking behaviors; living situation; family information; developmental information; spiritual beliefs/religious orientation; sexuality; need for and availability of social, community, and natural supports/resources; legal involvement history; legal status; education; employment; military services history; clinical formulation; diagnosis; individual's expression of service preferences; assessed needs/treatment recommendations; and signature of person completing the assessment. The annual assessment shall include: identification of clinical assessment sections for update; update narrative (only for sections identified as needing update); clinical formulation; diagnosis change/update; the individuals expression of service preferences; assessed needs/treatment recommendations; and signature of required staff.
Qualified provider: Qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP). The person rendering the diagnosis must be one of the following: physician (including psychiatrist); psychologist (licensed or provisionally licensed); advanced practice nurse; professional counselor (licensed or provisionally licensed); marital and family therapist (licensed or provisionally licensed); licensed clinical social worker; licensed master social worker under registered supervision with the Missouri Division of Professional Registration for licensure as a clinical social worker.
Limitations: Limited to 25 hours/100 units annually per individual.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 25 hours per ☐ Day ☐ Week ☐ Month ☑ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP). The person rendering the diagnosis must be one of the following: physician (including psychiatrist); psychologist (licensed or provisionally licensed); advanced practice nurse; professional counselor (licensed or provisionally licensed); marital and family therapist (licensed or provisionally licensed); licensed clinical social worker; licensed master social worker under registered supervision with the Missouri Division of Professional Registration for licensure as a clinical social worker.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified mental health professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider

qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ).

2. Provider Type: Qualified substance abuse professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR).

3. Provider Type: Physician, psychologist, advanced practice nurse, professional counselor, marital and family therapist, clinical social worker, master social worker
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: For the purposes of rendering a diagnosis, the provider types listed must be licensed in their field.

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Collateral Dependent Counseling

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Planned, face-to-face, goal-oriented therapeutic interaction in an individual or group setting to address dysfunctional behaviors and life patterns associated with being a member of a family in which an individual has a substance use and/or mental health disorder and is currently participating in treatment for a substance use and/or mental health disorder.
Qualified provider: A family therapist, or a qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP) who has training in family recovery. Limitations: Collateral dependent counseling shall only be a reimbursable service when provided to a person who is a member of an individual's family unit. The family unit includes others identified by the individual as a primary natural support. When provided in a group setting, the usual and customary size of groups that include only family members cannot exceed 12 family members in order to promote participation, disclosure and feedback. Groups that include both family members and primary individuals being served cannot exceed 20 in a session. The maximum billable units are 3 hours/12 units per day. Collateral dependent counseling services may be provided to children five years and younger only when the child can be shown to have the requisite social and verbal skills to participate in and benefit from the service.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 3 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: A family therapist, or a qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP) who has training in family recovery.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Family therapist
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): A marital and family therapist licensed in Missouri; an individual certified by the American Association of Marriage and Family Therapists; a person with a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling; or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements.

2. Provider Type: Qualified mental health professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ), and have training in family recovery.

3. Provider Type: Qualified substance abuse professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR), and have training in family recovery.

4. Provider Type:
License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No
Describe: _____

Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Community Support

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Community support services are individualized rehabilitative services and include the following billable activities:
•Direct contact in person or by phone with individuals.
•Direct contact in person or by phone with families, staff within the provider agency, and other agencies on behalf of the individual (excluding staff within the provider agency who are other CSSs, CSS supervisors, group staff, and program directors).
•Direct contact in person or by phone between two CSSs for the purpose of care coordination in the course of transitioning an individual from a youth program to an adult program.
•Direct contact in person or by phone between two CSSs for the purpose of care coordination, one of whom is working with an adolescent and one of whom is working with a parent, when both are MO HealthNet eligible individuals.
•Travel time required for making face-to-face contact with individuals, families, and other agencies.
•Time spent completing the DLA20©. A CSS may bill up to two (2) units of Community Support. The billable time should be the actual time spent completing the DLA20©, and may vary from one individual to another.
Community Support consists of specific activities with or on behalf of a individual in accordance with an individualized treatment plan. Services are provided to maximize an individual's immediate and continued community functioning while achieving and sustaining recovery/resiliency from mental illness and/or substance use disorders. These services are delivered in an amount and scope defined by each individual's plan, and not all plans will contain all services. Community Support services focus on helping individuals develop skills, access resources and learn to manage illness in order to be successful in the living, working, learning, and social environments of their choice. Community Support specialists teach, model, and practice skills with individuals served in order to increase self-sufficiency and independence. The specific skills and supports are addressed on an individualized treatment plan (ITP) and based on the life domains that the individual has identified as being impacted directly or indirectly by their serious mental illness, or substance use disorder, or both. Community Support services are time-limited based on individual need, and rehabilitative in nature. Community support services include the following functions:
•Providing holistic, person-centered care with emphasis on personal strengths, skill acquisition and harm reduction, while using stage-wise and motivational approaches that promote active participation by the individual in decision making and self-advocacy in all aspects of services and recovery/resiliency.
•Using interventions, based on individual strengths and needs, to develop interpersonal/social,

family, community and independent living functional skills including adaptation to home, school, family and work environments when the natural acquisition of those skills is negatively impacted by the individual's mental illness and/or substance use disorder.
•Facilitating and supporting recovery/resiliency through activities including: defining recovery/resiliency concepts in order to develop and attain recovery/resiliency goals; identifying needs, strengths, skills, resources and supports and teaching how to use them; and identifying barriers to recovery/resiliency and finding ways to overcome them.
•Developing, implementing, updating, and revising as needed, a treatment plan that identifies specific, measurable and individualized interventions to reduce and manage symptoms, improve functioning and develop stability and independence. This plan is developed by a team consisting of the following as appropriate: the individual, family, community support specialist, community support supervisor, therapist, medication providers, schools, child welfare, courts and other supports.
•Providing services that result in positive outcomes including but not limited to the following areas: employment/education, housing, social connectedness, abstinence/harm reduction, decreased criminality/legal involvement, family involvement, decreased psychiatric hospitalizations, decreased episodes of detoxification, reduction in emergency room visits, and improved physical health.
•Documenting services that clearly describes the need for the service, the intervention provided, the relationship to the treatment plan, the provider of the service, the date, actual time and setting of the service, and the individual's response to the service.
•Working collaboratively with the individual on treatment goals and services including the use of collaborative documentation as a tool to insure that individuals are active in their treatment.
•Developing a discharge and aftercare/continuing recovery plan to include, if applicable, securing a successful transition to continued services.
•Contacting individuals and/or referral sources following missed appointments in order to re-engage and promote recovery/resiliency efforts.
•Supporting individuals in crisis situations including locating and coordinating resources to resolve a crisis.
•Maintaining contact with individuals who are hospitalized for medical or behavioral health reasons and participate in and facilitate discharge planning for hospitalization as appropriate.
•Provide information and education in order to learn about and manage mental illness/serious emotional disturbance and/or substance use disorders including symptoms, triggers, cravings, and use of medications.
•Reinforce the importance of taking medications as prescribed, and assist the individual to make known to the prescriber medication concerns regarding side effects or lack of efficacy.
•Building skills for effective illness self-management including psychoeducation, behavioral tailoring for medication adherence, wellness/recovery planning, coping skills training, and social skills training.
•In conjunction with the individual, family, significant others and referral sources, identifying risk factors related to relapse in mental illness and/or substance use disorders and develop a plan with strategies to support recovery and prevent relapse.
•Make efforts to ensure that individuals gain and maintain access to necessary rehabilitative services, general entitlement benefits, employment, housing, education, legal services, wellness or other services by actively assisting individuals to apply and follow up on applications; and to gain skills in independently accessing needed services.
•Ensuring communication and coordination with and between other interested parties such as

service providers, medical professionals, referral sources, employers, schools, child welfare, courts, probation/parole, landlords, and natural supports.
•Ensuring follow through with recommended medical care, to include scheduling appointments, finding financial resources and arranging transportation when individuals are unable to perform these tasks independently.
•Developing and supporting wellness and recovery goals in collaboration with the individual, family and/or medical professionals, including healthy lifestyle changes such as healthy eating, physical activity and tobacco prevention and cessation; and coordinating and monitoring of physical health and chronic disease management.
•Assisting to develop natural supports including identification of existing and new natural supports in relevant life domains.
•In coordination with the treatment team, improving skills in communication, interpersonal relationships, problem solving, conflict resolution; stress management; and identifying risky social situations and triggers that could jeopardize recovery.
•Providing family education, training and support to develop the family as a positive support system to the individual. Such activities must be directed toward the primary well-being and benefit of the individual.
•Helping individuals develop skills and resources to address symptoms that interfere with seeking or successfully maintaining a job, including but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance.
•Building skills associated with obtaining and maintaining success in school such as communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identification of behaviors that interfere with school performance.
•Building personal self-care and home management skills associated with achieving and maintaining housing in the least restrictive setting by addressing issues like nutrition, meal preparation; household maintenance including house cleaning and laundry; money management and budgeting; personal hygiene and grooming; identification and use of social and recreational skills; use of available transportation; and personal responsibility.
Qualified provider: A Community Support Specialist must meet one of the following qualifications:
•A qualified mental health professional as defined in 9 CSR 10 – 7.140 (2) (QQ);
•An individual with a bachelor's degree in a human services field, which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science and rehabilitation counseling;
•An individual with any four year degree and two years of qualifying experience;
•An individual with any four year combination of higher education and qualifying experience; or
•An individual with four years of qualifying experience.
Qualifying experience must include delivery of service to individuals with mental illness, substance use disorders or developmental disabilities. Experience must include some combination of the following:
•Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;

•Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance use issues while encouraging the use of natural resources;
•Supporting efforts to find and maintain employment for individuals and/or to function appropriately in families, school and communities;
•Assisting individuals to achieve the goals and objectives on their individualized treatment or person centered plans.
It is also required that the Community Support Specialist complete the necessary orientation and training requirements specified by the Division of Behavioral Health. Individuals providing Community Support must be supervised by a qualified mental health professional (QMHP).
Limitations: Limited to 8 hours/32 units per day, and 50 hours/200 units per month.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 8 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: also limited to 50 hours per month

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: An individual meeting the Community Support Specialist qualifications described above.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: An individual meeting the Community Support Specialist qualifications described above.
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Crisis Intervention

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Crisis intervention is face-to-face emergency or telephone intervention services, available 24 hours a day on an unscheduled basis to the individual. The services are designed to resolve the crisis, provide support and assistance, and to promote a return to routine adaptive functioning. Crisis intervention is reimbursable only when the individual's community support specialist is unavailable or unable to resolve a crisis situation. Key service functions for crisis intervention include:
•Interacting with the identified individuals' family members, legal guardian, significant others, or a combination of these;
•Specifying factors that led to the individuals' crisis state, when known;
•Identifying maladaptive reactions exhibited by the individual;
•Evaluating potential for rapid regression;
•Attempting to resolve the crisis; and
•Referring the individual for treatment in an alternative setting, when indicated.
Treatment is designed to resolve the individuals presenting crisis; furnish support and assistance; develop symptomatic relief; and facilitate return to routine adaptive functioning.
Qualified provider: A qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP).

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: A qualified mental health professional or qualified substance abuse professional

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified mental health professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ).

2. Provider Type: Qualified substance abuse professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR).

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Family Conference

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
An intervention service that coordinates care with, and enlists the support of, the natural support system through meeting with family members, referral sources, and significant others about the individual's treatment plan and discharge plan. The service shall be delivered in the presence of the individual. Additional key service functions include the following:
•Communicating about issues at home that are barriers to treatment plan goals;
•Identifying relapse triggers and establishing a relapse prevention plan;
•Participating in a discharge conference; and
•Assessing the need for family therapy or other referrals to support the family system. Qualified provider: Family conference is provided by a qualified mental health professional (QMHP), qualified substance abuse professional (QSAP), or an associate substance abuse counselor. Limitations: This service is limited to a maximum of 2 hours/8 units per day, per individual.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 2 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified mental health professional (QMHP), qualified substance abuse professional (QSAP), or an associate substance abuse counselor.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified mental health professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ)

2. Provider Type: Qualified substance abuse professional
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR)

3. Provider Type: Associate substance abuse counselor
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (I).

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Family Support

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Services designed to provide a support system for parents of young adults up to age 26. Activities are directed and authorized by the individual's treatment plan. Key service functions include, but are not limited to the following:
•Providing information and support to the parent/caregiver so they have a better understanding of the individuals needs and exploring options to be considered as part of their treatment.
•Assisting the parent/caregiver in understanding the planning process and the importance of their voice in the development and implementation of the individualized treatment plan.
•Providing support to empower the parents/caregivers to be a voice for the individual and family in the planning meeting.
•Working with the family to highlight the importance of individualized planning and the strengths-based approach.
•Assisting the family in understanding the roles of the various providers and the importance of the "team" approach.
•Discussing the benefit of natural supports within their family and community.
•Introducing methods for problem solving and developing strategies to address issues that need work.
•Providing support and information to parents/caregivers of transition age youth related to the shift from being the decision maker to being the support to the individual as they become more independent.
•Connecting families to community resources.
•Empowering parents/caregivers/young adults to become involved in activities related to planning, development, implementation, and evaluating programs and services.
•Connecting parent's/caregivers/young adults to others who have had similar lived experiences to increase their support system.
The specific skills and activities that are the focus of this intervention will be identified on the individual's treatment plan and are developmentally appropriate. Collateral contact may be billed. Travel time required for making face-to-face contact with individuals, families, and other agencies may be billed.
Qualified provider: The eligible provider must be a family member of a young adult who had or currently has a behavioral health disorder or a substance use disorder, has a high school diploma or equivalent, has completed training as required by department policy, and is supervised by a qualified mental health professional (QMHP) or a qualified substance abuse professional (QSAP).
Limitations: Limited to 8 hours/32 units per day, and 24 hours/96 units per month.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under

the Demonstration:

Benefit Amount: 8 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: also limited to 24 hour per month

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: The eligible provider must be a family member of a young adult who had or currently has a behavioral health disorder or a substance use disorder, has a high school diploma or equivalent, has completed training as required by department policy, and is supervised by a qualified mental health professional (QMHP) or a qualified substance abuse professional (QSAP)

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualifications of allowable provider described above
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Family Therapy

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Planned, face-to-face goal oriented therapeutic interaction in an office or home setting with a qualified staff member in accordance with the individual's treatment plan. The purpose of family therapy is to address and resolve problems in family interaction related to mental health and substance use issues. One or more family members must be present at all family therapy sessions. In any calendar month, for at least 50% of an individual's family therapy, the individual must be present, in addition to one or more members of the individuals' family. Family members below the age of 12 can be counted as one of the required family members when the child is shown as having the requisite social and verbal skills to participate in and benefit from the service. Key service functions include, but are not limited to:
•Utilization of generally accepted principles of family therapy to influence family interaction patterns;
•Examination of family interaction styles and confronting patterns of dysfunctional behavior and strengthening communication patterns that promote healthy family function;
•Facilitation of family participation in family self-help recovery groups;
•Development and application of skills and strategies for improvement in family functioning; and,
•Generalization and stabilization of change to promote healthy family interaction independent of formal helping systems.
Qualified provider: Family therapy shall be performed by a person who:
•Is licensed in Missouri as a marital and family therapist; or
•Is certified by the American Association of Marriage and Family Therapists; or
•Has a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling; or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements; or,
•Is a qualified substance abuse professional (QSAP) or qualified mental health professional (QMHP) who receives close supervision from an individual that meets the above requirements.
Limitations: Limited to 3 hours/12 units per day. When provided in a home setting, driving time to and from the individual's home for the purpose of in-home therapy or assessment is not reimbursable.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 3 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: A marital and family therapist licensed in Missouri; an individual certified by the American Association of Marriage and Family Therapists; a person with a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling, or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements; or, a qualified substance abuse professional (QSAP) or qualified mental health professional (QMHP) who receives close supervision from an individual that meets the above requirements.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Marital and family therapist licensed in Missouri
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: An individual certified by the American Association of Marriage and Family Therapists

License Required: ☐Yes ☑No

Certificate Required: ☑Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

3. Provider Type: A person with a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling, or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements.

License Required: ☐Yes ☑No

Certificate Required: ☐Yes ☑No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

4. Provider Type: A qualified substance abuse professional (QSAP) or qualified mental health professional (QMHP) who receives close supervision from an individual that meets the above requirements

License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ) or 9 CSR 10-7.140 (2) (RR).

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Group Counseling

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Group counseling is a face-to-face, goal-oriented therapeutic interaction between a counselor and two or more individuals as specified in an individual's treatment plan designed to promote the individuals functioning and recovery through personal disclosure and interpersonal interaction among group members. Key service functions of group counseling may include, but are not limited to, the following:
•Facilitate individual disclosure of mental health and substance use-related issues which permits generalization of the issues to the larger group;
•For individuals with substance use disorders, promote recognition of addictive thinking and behaviors and teaching sobriety based thinking and behavior;
•For individuals with substance use disorders, prepare individuals to cope with physical, cognitive and emotional symptoms of drug craving;
•Encourage and model productive and positive interpersonal communication; and
•Develop motivation and action by group members through peer influence, structured confrontation and constructive feedback.
For individuals with co-occurring mental health and substance use disorders, this service is designed to promote individuals self-understanding, self-esteem and resolution of personal problems related to the individuals documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. Group co-occurring counseling involves the use of evidence-based practices such as motivational interviewing, cognitive behavior therapy and relapse prevention.
Qualified provider: An associate substance abuse counselor, qualified substance abuse professional (QSAP), or licensed qualified mental health professional (QMHP). For individuals with co-occurring mental health and substance use disorders, the provider must be a licensed QMHP or a QSAP, who meets co-occurring counselor competency requirements established by the Department of Mental Health.
Limitations: Limited to 3 hours/12 units per day. Group size may not exceed 12 individuals. For co-occurring group counseling, group size may not exceed 10 individuals. When using an associate counselor or qualified substance abuse professional (QSAP), to deliver this service, the organization must have a substance use disorder contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 3 hours per ☐ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: An associate substance abuse counselor, qualified substance abuse professional (QSAP), or licensed qualified mental health professional (QMHP). For individuals with co-occurring mental health and substance use disorders, the provider must be a QMHP or a QSAP, who meets co-occurring counselor competency requirements established by the Department of Mental Health.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Associate substance abuse counselor
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (I).

2. Provider Type: Qualified substance abuse professional (QSAP)
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR). For individuals with co-occurring mental health and substance use disorders, the provider must meet co-occurring counselor competency requirements established by the Department of Mental Health.

3. Provider Type: Licensed qualified mental health professional (QMHP)
   License Required: ☑Yes ☐No

   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ). For individuals with co-occurring mental health and substance use disorders, the provider must meet co-occurring counselor competency requirements established by the Department of Mental Health.

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Group Psychoeducation

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Group psychoeducation consists of the presentation of mental health and substance use information and application of the information by individuals through group discussion in accordance with individualized treatment plans which are designed to promote recovery and enhance social functioning. Key service functions of group psychoeducation may include, but are not limited to, the following:
•Classroom style didactic lecture to present information about a topic and its relationship to substance use/misuse and/or mental illness;
•Presentation of audio-visual materials that are educational in nature with required follow up discussion;
•Promotion of discussion and questions about the topic presented to the individuals in attendance; and
•Generalization of the information and demonstration of its relevance to recovery and enhanced functioning.
The agency must develop a schedule and curriculum for delivery of group psychoeducation services addressing topics and material relevant to the individuals served, and must be goal oriented rehabilitative services provided in a group setting as outlined in an individual's treatment plan. Services delivered are based on need and may include:
•The progressive nature of substance use disorders and the disease model, principles and availability of self-help groups and health and nutrition;
•The personal recovery process, including the recognition of loss of control, education on diagnosis, feelings and behavior, promoting self-awareness and self-esteem, encouraging personal responsibility and constructively using leisure time;
•Skill development designed to maintain and improve the ability of individuals to function as independently as possible in their family and/or community;
•Skill development, such as communication skills, stress reduction and management, conflict resolution, decision making, assertiveness training, completing employment applications and employment interviewing and parenting;
•Skill development, such as addressing diet, personal hygiene, cooking, and budgeting;
•Promotion of positive family relationships and family recovery;
•Relapse prevention and symptom management;
•Effects of alcohol and other substance use upon pregnancy and child development; and
•Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases, including related conditions, risk factors, preventative measures and the availability of diagnostic testing.
For individuals with co-occurring mental health and substance use disorders, these services are designed to assist individuals, family members, and others identified by the individual as a primary

natural support in the management of mental health and substance use disorders. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and substance use disorders which includes integrating emotional aspects in order to enable the individuals, as well as family members, cope with the illness and understand the importance of their individual plan of treatment. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms, understanding of the "triggers" of crisis, crisis planning, community resources, recovery management, medication action and interaction. Co-occurring group psychoeducation focuses on evidence-based practices such as promotion of an individual's participation in peer self-help, brain chemistry and functioning, latest research on illness causes and treatments, medication education and management, symptom management, behavior management, stress management, and improving daily living skills and independent living skills. For individuals with trauma related issues, this service requires presentation of recovery and trauma related information in the context of mental illness and/or substance use disorders, and its application to individuals along with group discussion in accordance with individualized treatment plans.
Qualified provider: Group psychoeducation services shall be provided by an individual who:
•Is suited by education, background or experience to teach the information being presented;
•Demonstrates competency and skill in educational techniques;
•Has knowledge of the topic(s) being taught; and,
•Is present with individuals throughout the group psychoeducation session.
For individuals with co-occurring mental health and substance use disorders, eligible providers must have documented education and experience related to the topic presented and either be or be supervised by a qualified mental health professional (QMHP) or a qualified substance abuse professional (QSAP), who meets co-occurring counselor competency requirements established by the Department of Mental Health.
For individuals with trauma related issues, group psychoeducation must be provided by staff with specialized trauma training, and training or equivalent work experience in substance use disorders and/or mental illness, as appropriate.
Limitations: Limited to 4 hours/16 units per day. Group size is limited to 30 individuals. For individuals with co-occurring mental health and substance use disorders, and individuals with trauma related issues, group size is limited to 20 individuals.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 4 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: Group psychoeducation services shall be provided by an individual who:
•Is suited by education, background or experience to teach the information being presented;
•Demonstrates competency and skill in educational techniques;
•Has knowledge of the topic(s) being taught; and,
•Is present with individuals throughout the group psychoeducation session.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified provider is described above.
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required:

Certificate Required: ☐Yes ☐No

☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: HIV/TB Pre/Post Test Counseling

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
HIV pre-test counseling is counseling for the purpose of assessing an individual's risk of exposure to HIV. This service includes an HIV risk assessment interview, an HIV pre-test counseling session, and appropriate documentation of the pre-test counseling session. For individuals testing positive for HIV, post-test counseling is provided and includes the appropriate documentation and medical, social, and psychological referrals as needed or requested by the individual. For individuals testing positive for TB, this service consists of a counseling session including test results and documentation. If appropriate, referrals may be made to local TB clinics.
Qualified provider: Staff providing this service must be knowledgeable about communicable diseases including HIV, TB, and STDs through training and/or previous employment experience. Staff knowledge shall include awareness of risks, disease management/treatment and resources for care, and confidentiality requirements when working with special populations. Staff providing these services shall also be competent to therapeutically assist individuals to understand and appropriately respond to test results.
Limitations: HIV pre-test counseling and HIV/TB post-test counseling are each limited to one 15 minute unit per episode of care. HIV pre-test counseling must be used with the following diagnosis code: Z20.6. HIV/TB post-test counseling must be used with one of the following diagnosis codes: Z20.6 or Z20.1. This service may only be provided by an organization with a substance use disorder contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: Limited to 1 unit of pre-test counseling and 1 unit of posttest counseling per episode of care per individual

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: Staff providing this service must be knowledgeable about communicable diseases including HIV, TB, and STDs through training and/or previous employment experience. Staff knowledge shall include awareness of risks, disease management/treatment and resources for care, and confidentiality requirements when working with special populations. Staff providing these services shall also be competent to therapeutically assist individuals to understand and appropriately respond to test results.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified provider described above.
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required:

Certificate Required: ☐Yes ☐No

☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No
Describe: _____

Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Individual Counseling

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
A structured, goal-oriented therapeutic process in which an individual interacts on a face to face basis with a counselor in accordance with the individual's treatment plan to resolve problems related to a mental illness or substance use disorder that interfere with the individual's functioning and personal, family, or community adjustment. Key service functions of individual counseling may include, but are not limited to the following:
•Exploration of an identified problem and its impact on an individual's functioning;
•Examination of attitudes and feelings, and behaviors that promote recovery and improved functioning;
•Identification and consideration of alternatives and structured problem solving;
•Decision-making; and
•Application of information presented in the program to the life situations in order to promote recovery and improve functioning.
When provided to individuals with co-occurring mental health and substance use disorders, this service involves the use of evidence-based practices such as motivational interviewing, cognitive behavior therapy and relapse prevention, and may include face-to-face interaction with one or more members of the individual's family for the purpose of assessment or supporting the individual's recovery.
When provided to individuals with trauma related issues, this service is designed to resolve issues related to psychological trauma in the context of mental health and substance use disorder problems. Personal safety and empowerment of the individual must be addressed.
Qualified provider: Associate substance abuse counselor, qualified substance abuse professional (QSAP), licensed qualified mental health professional (QMHP). For individual counseling with persons with co-occurring mental health and substance use disorders, the qualified provider must be a licensed QMHP or QSAP, who meets co-occurring counselor competency requirements established by the Department of Mental Health. For individual counseling with persons with trauma related issues, the qualified provider must be a licensed QMHP or QSAP, and have specialized trauma training and/or equivalent work experience approved by the Department of Mental Health.
Limitations: Limited to 3 hours/12 units per day. When using an associate substance abuse counselor or qualified substance abuse professional (QSAP), to deliver this service, the organization must have a substance use disorder contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 3 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: Associate substance abuse counselor, qualified substance abuse professional (QSAP), licensed qualified mental health professional (QMHP). For individual counseling with persons with co-occurring mental health and substance use disorders, the qualified provider must be a licensed QMHP or QSAP, who meets co-occurring counselor competency requirements established by the Department of Mental Health. For individual counseling with persons with trauma related issues, the qualified provider must be a licensed QMHP or QSAP, and have specialized trauma training and/or equivalent work experience approved by the Department of Mental Health.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Associate substance abuse counselor
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (I).

2. Provider Type: Qualified substance abuse professional (QSAP)
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR). For counseling with persons with co-occurring mental health and substance use disorders, the provider must meet co-occurring counselor competency requirements established by the Department. For counseling with persons with trauma related issues, the provider must have specialized trauma training and/or equivalent work experience approved by the Department.

3. Provider Type: Licensed qualified mental health professional (QMHP)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ). For counseling with persons with co-occurring mental health and substance use disorders, the provider must meet co-occurring counselor competency requirements established by the Department. For counseling with persons with trauma related issues, the provider must have specialized trauma training and/or equivalent work experience approved by the Department.

4. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Intensive Evidence Based Practices

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Implementation of supports for treatments that have been proven demonstratively effective for young adults. The selected evidence based practice is based on the individual's needs and desired outcomes and is identified on the treatment plan. Activities associated with the service include, but are not limited to:
•Extensive monitoring and data collection;
•Specific skills training components in a prescribed or natural environment; and
•Prescriptive responses to psychiatric crisis and/or frequent contact with the individual or family in addition to the arranged therapy sessions.
Evidence based practices currently billable to this procedure code are limited to: Functional Family Therapy, Multi-Systematic Therapy, and Dialectical Behavior Therapy. Additional evidence based practices may be added as billable under this procedure code with approval by the Division of Behavioral Health.
Qualified provider: An agency approved by the Division of Behavioral Health.
Limitations: Limited to 1 unit per day per individual. This service may only be provided by an organization with a mental health contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 1 unit per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: _____

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified provider described above.
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Medically Monitored Inpatient Detoxification

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
This service is the provision of care to individuals whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care and monitoring; however, the full resources of a hospital setting are not necessary.
Qualified provider: A physician or advanced practice nurse (APN) must be on call 24 hours per day, seven days per week to provide medical evaluation and ongoing withdrawal management. Licensed nursing staff must be present 24 hours per day. A Registered Nurse (RN) with relevant education, experience and competency must be available on site or by phone for 24 hour supervision. Two trained staff members must be on-site at all times to insure continuous supervision and safety.
Limitations: Limited to 1 unit per day. Length of stay in an MMID program is limited to five days. Additional days may be authorized through Clinical Utilization Review. This service may only be provided by an organization with a substance use disorder contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 1 unit per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: Limited to 5 days per episode

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: Additional days may be authorized through Clinical Utilization Review

Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: An organization with a substance use disorder contract with the Division of Behavioral Health must meet the following requirements: A physician or advanced practice nurse (APN) must be on call 24 hours per day, seven days per week to provide medical evaluation and ongoing withdrawal management. Licensed nursing staff must be present 24 hours per day. A Registered Nurse (RN) with relevant education, experience and competency must be available on site or by phone for 24 hour supervision. Two trained staff members must be on-site at all times to insure continuous supervision and safety.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: An organization with a substance use disorder contract with the Division of Behavioral Health

License Required: ☐Yes ☐No

Certificate Required: ☑Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

2. Provider Type:

License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

3. Provider Type:

License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe: _____

Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Medication Management

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Medication management consists of goal oriented interaction to assess an individual for the appropriateness of medications to treat a mental health or substance use disorder, prescribe appropriate medications, and provide ongoing management of a medication regimen. Key service functions include, but are not limited to:
•an assessment of the individual's presenting condition;
•a mental status exam;
•a review of symptoms and medication side effects;
•a review of the individual's functioning;
•assessment of the individual's ability to self-administer medications;
•education regarding the effects of medication and its relationship to the individual's mental health or substance use disorder; and
•prescription of medications, when indicated.
Qualified provider: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist.
Limitations: Limited to one per day, may not be billed on the same date as Psychiatric Diagnostic Evaluation. Must meet all billing requirements for evaluation/management services specified in the Current Procedural Terminology (CPT) catalog. Psychiatric Pharmacists are limited to serving established individuals only. This service may be provided through telehealth.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 1 per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: May not be billed on same day as Psychiatric Diagnostic Evaluation

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist. Psychiatric Pharmacists are limited to serving established individuals only.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Physician
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type: Child Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

Other Qualifications required for this Provider Type (please describe):

4. Provider Type: Psychiatric Resident
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

5. Provider Type: Advanced Practice Nurse
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

6. Provider Type: Psychiatric Pharmacist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

7. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

8. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Metabolic Syndrome Screening

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Metabolic screening is an annual screening for the following risk factors: obesity, hypertension, hyperlipidemia, and diabetes. Specific activities may include but are not limited to:
•Taking and recording of vital signs.
•Conducting lab tests to assess lipid levels and blood glucose levels and/or HgbA1c.If the lab tests are conducted by the nurse, they must use an analyzer approved by theDepartment of Mental Health.
•Arranging for and coordinating lab tests to assess lipid levels and blood glucose levels and/or HgbA1c.
•Obtaining results of recently completed lab tests from other health care providers to assess lipid levels and blood glucose levels and/or HgbA1c.
Qualified provider: Registered nurse (RN) or Licensed practical nurse (LPN).
Limitations: Limited to one per 90 days per individual. In order to bill this service the provider must complete the Metabolic Syndrome Screening and Monitoring Tool and record the results of the screening in a department approved data collection system.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: One unit per 90 days

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Registered nurse (RN) or Licensed practical nurse (LPN)

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Registered nurse (RN)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Licensed practical nurse (LPN)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Methadone Dosing

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Methadone dosing consists of the delivery of methadone medication to individuals in an Opioid Treatment Program for ongoing maintenance treatment and medically supervised withdrawal from opiates.
Qualified provider: The eligible provider to prescribe methadone in an opioid treatment setting must be a Physician licensed in Missouri. The eligible provider to administer Methadone must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN).
Limitations: Emergency Medication: The medical director may grant emergency take-home doses of methadone based on emergency circumstances. The circumstances and basis for the action must be documented in the individual's record. Take-home doses for in-state emergencies are limited to a maximum of three (3) doses and out-of-state are limited to a maximum of five (5) doses. Additional take-home doses must be authorized through the exception request process. Vacation Medication: The medical director may grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the individual's record. Additional take-home medication must be authorized through the exception request process. This service may only be provided by an organization with a substance use disorder contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 1 per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: Take-home doses for in-state emergencies are limited to a maximum of three (3) doses and out-of-state are limited to a maximum of five (5) doses. Additional take-home doses must be authorized through the exception request process. Vacation Medication: The medical director may grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the individual's record. Additional take-home medication must be authorized through the exception request process.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: The eligible provider to prescribe methadone in an opioid treatment setting must be a Physician licensed in Missouri. The eligible provider to administer methadone must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Physician
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe_____

   Other Qualifications required for this Provider Type (please describe): Licensed physician is required to prescribe methadone.

2. Provider Type: Registered Nurse (RN)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Registered Nurse is required to administer methadone.

3. Provider Type: Licensed Practical Nurse (LPN)
   License Required: ☑Yes ☐No

   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Licensed Practical Nurse is required to administer methadone.

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Nursing Services

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
This service consists of medical and other consultative services provided for the purposes of monitoring and managing an individual's health, and medication management. Activities include the following:
•Any therapeutic injection of medication;
•Monitoring lab levels including consultation with physicians, individuals, and clinical staff;
•Obtaining initial individual medical histories and taking vital signs;
•An initial and annual health screen that includes the individual's health history and risk factors;
•Coordinating medication needs with pharmacies, prescribers, individuals, and families, including the use of indigent drug programs (excluding the routine placing of prescription orders and refills with pharmacies);
•Monitoring medication side effects, including the use of standardized evaluations;
•Monitoring physician orders for treatment modifications requiring individual's education;
•Reviewing medication requirements with the individual, educating the individual about the benefits of taking medications as prescribed, and monitoring medication compliance;
•Consulting with individuals on use of over-the-counter medications and monitoring their use;
•Setting up medication boxes;
•Monitoring general health needs and meeting with individuals about medical concerns;
•Providing disease prevention, risk reduction and reproductive health education;
•Triaging medical conditions that occur during treatment and managing medical emergencies;
•Conferring with a physician as necessary or advocating for medical services through managed care organizations;
•Arranging or monitoring special dietary needs for medical conditions;
•Evaluation of the individual's physical condition and the need for social setting detoxification services (substance use disorder providers only); and
•Monitoring health status during detoxification (substance use disorder providers only).
Qualified provider: Registered nurse (RN) or Licensed practical nurse (LPN).
Limitations: Limited to 4 hours/16 units per day per individual.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 4 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: _____

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Registered nurse (RN)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Licensed practical nurse (LPN)
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Peer Support

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
The purpose of peer support services is to assist individuals served in their recovery from mental illness or substance use disorders. The treatment plan of the individual served shall determine the focus of this service. Peer support services are person-centered with a recovery focus. Services allow individuals the opportunity to direct their own recovery and advocacy processes. Peer support services promote skills for coping with and managing symptoms while facilitating the utilization of natural supports and the preservation and enhancement of community living skills. Services are provided by an individual with the lived experience of recovery from a mental illness and/or substance use disorder. Peer Support services may include, but are not limited to, the following:
•Helping individuals connect with other individuals, and their communities at large in order to develop a network for information and support;
•Sharing lived experiences of recovery, sharing and supporting the use of recovery tools, and modeling successful recovery behaviors;
•Helping individuals to make independent choices and to take proactive roles in their treatment;
•Assisting individuals with identifying strengths and personal resources to aid in their setting and achieving recovery goals;
•Assisting individuals in setting and following through on goals;
•Supporting efforts to find and maintain paid, competitive, integrated employment; and
•Assisting with health and wellness activities.
Qualified provider: A Certified Missouri Peer Specialist with at least a high school diploma or equivalent and applicable training and testing as required by the department and supervised by a qualified mental health professional (QMHP); or a Missouri Recovery Support Specialist who is peer credentialed by the Missouri Credentialing Board and supervised by a qualified substance abuse professional (QSAP). Peer Specialists shall be considered a member of the treatment team and shall participate in staff meeting discussions regarding the care of individuals served.
Limitations: Limited to 8 hours/32 units per day, and 24 hours/96 units per month. Certified Peer Specialists and Missouri Recovery Support Specialists shall not be assigned an individual caseload.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 8 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: also limited to 24 hours per month

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: A Certified Missouri Peer Specialist with at least a high school diploma or equivalent and applicable training and testing as required by the department and supervised by a qualified mental health professional (QMHP); or a Missouri Recovery Support Specialist who is peer credentialed by the Missouri Credentialing Board and supervised by a qualified substance abuse professional (QSAP).

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Certified Missouri Peer Specialist
   License Required: ☐Yes ☑No
   Certificate Required: ☑Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Missouri Recovery Support Specialist
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

Other Qualifications required for this Provider Type (please describe): Must be peer credentialed by the Missouri Credentialing Board and supervised by a qualified substance abuse professional (QSAP)

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Professional Consultation

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Coordination of care with other physicians, other qualified health care professionals, or agencies, provided consistent with the nature of the problem(s) and the individuals and/or family's needs. This includes a review of an individual's current medical situation through consultation with a staff person or in team discussions relating to a specific individual. Activities may include the following:
•An assessment of the individual's presenting condition as reported by staff;
•Review of the treatment plan through consultation;
•Individual-specific consultation to staff especially in situations which pose high risk of decompensation, hospitalization, or safety issues; and
•Individual-specific recommendations regarding high risk issues and when needed to promote early intervention.
Qualified provider: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist.
Limitations: Limited to 8 units/2 hours per day. This service may be provided through telehealth.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 2 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Physician
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type: Child Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type: Psychiatric Resident
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

5. Provider Type: Advanced Practice Nurse
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

6. Provider Type: Psychiatric Pharmacist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

7. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

8. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Psychiatric Diagnostic Evaluation

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
An integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.
Qualified provider: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist.
Limitations: Limited to 8 units/2 hours per day, and 12 units/3 hours annually. May not be billed on the same date as Medication Management. This service may be provided through telehealth.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 2 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: Also limited to 3 hours annually. May not be billed on same day as Medication Management.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Physician, Psychiatrist, Child Psychiatrist, Psychiatric Resident, Advanced Practice Nurse, Psychiatric Pharmacist

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Physician
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type: Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type: Child Psychiatrist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type: Psychiatric Resident
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

5. Provider Type: Advanced Practice Nurse
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

6. Provider Type: Psychiatric Pharmacist
   License Required: ☑Yes ☐No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

7. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

8. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Psychosocial Rehabilitation – Illness, Management and Recovery

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
The psychosocial rehabilitation program may provide illness management and recovery services that promote physical and mental wellness; well-being; self-direction; personal empowerment; respect; and responsibility in individual and group settings. Services shall be person-centered and strength-based and include, but are not limited to, the following:
•Psychoeducation;
•Relapse prevention;
•Coping skills training.
In the event that a program is accredited by the Clubhouse International and submits its accreditation report, it will be deemed as a PSR-IMR program.
Qualified provider: An agency approved by the Division of Behavioral Health.
Limitations: Limited to 10 hours/40 units per day. The maximum group size shall not exceed eight (8) individuals; however if there are other curriculum based approaches that suggest different group size guidelines, larger group sizes may be approved by the Division of Behavioral Health. This service may only be provided by an organization with a mental health contract with the Division of Behavioral Health.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 10 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: An agency approved by the Division of Behavioral Health.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: An agency approved by the Division of Behavioral Health
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

2. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

3. Provider Type:
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Supported Employment

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
Supported Employment is a support service to facilitate competitive work in an integrated work setting. The service must be identified in the individual's treatment plan based upon an individualized assessed need which promotes the greatest degree of integration, independence and autonomy. Supported Employment services may include:
•Job development services including staff calls on potential employers and employment settings, with or without the presence of the individual served, in order to determine appropriate job matches for individuals served, whether or not the individual served chooses to disclose disability status. Job development includes staff activities that are focused on working with employers as customers to help them meet business needs while providing good job matching for individuals served.
•Ongoing supervision and monitoring of the individuals performance on the job; i.e. evaluating self-maintenance strategies, work production and the effectiveness of natural supports which promote the greatest degree of inclusion, integration and autonomy.
•Training in related skills needed to retain employment; i.e. supporting and facilitating strategies which promote attendance and social inclusion in the workplace based upon individualized assessed need such as using community resources and public transportation.
•On-the-job training in work and work-related skills; i.e. job coaching to facilitate the acquisition, and ongoing performance, of the essential functions of the job and the facilitation of natural supports.
Supported employment services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect. Services will be provided in accordance with section 110 of the Rehabilitation Act of 1973 and its amendments and will be specified in an interagency MOU assuring non-duplication. Supported Employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business or otherwise covered under the Americans with Disabilities Act. All Supported Employment service options should be reviewed and considered as a component of an individual's person-centered treatment plan. These services and supports should be designed to support successful employment outcomes consistent with the individual's assessed goals, needs, interests and preferences. Individuals must be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Qualified provider: A community support specialist, certified Missouri peer support specialist, or employment specialist. Staff must have specialized training approved by the Department of Mental Health.
Limitations: Limited to 8 hours/32 units per day, and 24 hours/96 units per month.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 8 hours per ☑ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe: also limited to 24 hours per month

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: A community support specialist, certified Missouri peer support specialist, or employment specialist. Staff must have specialized training approved by the Department of Mental Health

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Community Support Specialist
   License Required: ☐Yes ☑No
   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Staff must have specialized training approved by the Department of Mental Health.

2. Provider Type: Certified Missouri Peer Support Specialist
   License Required: ☐Yes ☑No

   Certificate Required: ☑Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Staff must have specialized training approved by the Department of Mental Health.

3. Provider Type: Employment Specialist
   License Required: ☐Yes ☑No

   Certificate Required: ☐Yes ☑No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Staff must have specialized training approved by the Department of Mental Health.

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Treatment Planning

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:
The development, review, and/or revision of an individual's treatment plan. The treatment plan shall include the following components:
•Identifying information
•Measurable goals
•Specific treatment objectives
•Specific interventions
•Identification of other agencies/community supports
•Estimated discharge/transition plan
Qualified provider: Qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP). Initial treatment plans require signatures of the following: the individual completing the plan, a Community Support Supervisor (if different from the individual completing the plan), and the individual or parent/legal guardian. The physician/APN must sign the plan within 90 days of eligibility determination. The annual treatment plan requires signatures of: QMHP/QSAP, the Community Support Specialist, the individual or parent/legal guardian, and the physician/APN.
Limitations: Limited to 50 hours/200 units annually per individual.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 50 hours per ☐ Day ☐ Week ☐ Month ☑ Year

☐ Other, describe: _____

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration: _____

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any: _____

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☐ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers: Qualified provider: Qualified mental health professional (QMHP) or qualified substance abuse professional (QSAP). Initial treatment plans require signatures of the following: the individual completing the plan, a Community Support Supervisor (if different from the individual completing the plan), and the individual or parent/legal guardian. The physician/APN must sign the plan within 90 days of eligibility determination. The annual treatment plan requires signatures of: QMHP/QSAP, the Community Support Specialist, the individual or parent/legal guardian, and the physician/APN.

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: Qualified mental health professional (QMHP)
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (QQ).

2. Provider Type: Qualified substance abuse professional (QSAP)
   License Required: ☐Yes ☐No
   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe): Must meet provider qualifications specified in state regulation 9 CSR 10-7.140 (2) (RR).

3. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):

4. Provider Type:
   License Required: ☐Yes ☐No

   Certificate Required: ☐Yes ☐No
   Describe: _____

   Other Qualifications required for this Provider Type (please describe):