Optum

Optum Behavioral Health Solutions
Medicaid State-Specific
Supplemental Clinical Criteria

Kentucky Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

Effective June 30, 2023, prior authorization is required for ASAM levels of care 3.1, 3.5, 3.7 and 4.0.

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

- ASSERTIVE COMMUNITY TREATMENT, is an evidence-based psychiatric rehabilitation practice that provides a comprehensive approach to service delivery for individuals with a serious mental illness. Services Include:
  - Assessment;
  - Treatment planning;
  - Case management;
  - Psychiatric services;
  - Individual outpatient therapy;
  - Family outpatient therapy;
  - Group outpatient therapy;
  - Mobile crisis services;
  - Crisis intervention;
  - Mental health consultation; or
  - Family support and basic living skills; and
  - Be provided face-to-face.

Service Delivery

- Mental health consultation shall involve brief, collateral interactions with other treating professionals who may have information for the purpose of treatment planning and service delivery.
  - Family support shall involve the assertive community treatment team's working with the recipient's natural support systems to improve family relations in order to:
    - Reduce conflict; and
    - Increase the recipient's autonomy and independent functioning.
  - Basic living skills shall be rehabilitative services focused on teaching activities of daily living necessary to maintain independent functioning and community living.
- To provide assertive community treatment services, a behavioral health services organization shall:
  - Employ at least one (1) team of multidisciplinary professionals:
    - Led by an approved behavioral health services practitioner; and
    - Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, an approved behavioral health services practitioner, ~~or~~ and a case manager;
  - Have adequate staffing to ensure that a team's caseload size shall not exceed ten (10) participants per team member (for example, if the team includes five (5) individuals, the caseload for the team shall not exceed fifty (50) recipients);
  - Have the capacity to:
    - Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;
    - Coordinate the provision of services among team members;
    - Provide the full range of assertive community treatment services as stated in this paragraph; and
    - Document and maintain individual case records; and
  - Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.
- Assertive community treatment shall be provided by:
  - An approved behavioral health practitioner; or
  - An approved behavioral health practitioner under supervision.
- A peer support specialist under the supervision of an approved behavioral health practitioner may provide support services under this paragraph.
- A community support associate under supervision of an approved behavioral health practitioner may provide support services under this paragraph.

For additional clinical criteria, please apply the Level of Care Utilization System (LOCUS):

- Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages 18 and older.
- Access the LOCUS criteria here: Level of Care Utilization System for Psychiatric and Addiction Services - Adult version

Behavioral Health Day Treatment

BEHAVIORAL HEALTH DAY TREATMENT is an organized behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder).

Admission Criteria

A member requires a non-residential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

- A mental health disorder, or substance use disorder, or co-occurring mental health and substance use disorders; and
- A high risk of out-of-home placement due to a behavioral health issue.

Service Delivery

- Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
- Behavior management and social skill training;
- Independent living skills that correlate to the age and developmental stage of the recipient; and
- Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and
- Services are provided:
    - In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act)
    - On school days and during scheduled breaks;
    - In coordination with the recipient's individual educational plan or Section 504 plan if the recipient has an individual educational plan or Section 504 plan;
    - Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision;
        - Day treatment shall be provided by:
            - An approved behavioral health practitioner; or
            - An approved behavioral health practitioner under supervision.
    - With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider;
    - Face-to-face.
- The Day Treatment provider has:
    - The capacity to employ staff authorized to provide day treatment services in accordance with this section and to coordinate the provision of services among team members;
    - Knowledge of substance use and mental health disorders.
- Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan or Section 504 plan.

Comprehensive Community Support Services

COMPREHENSIVE COMMUNITY SUPPORT SERVICES cover activities necessary to allow individuals with mental illness to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual service plan. Skills training is designed to reduce mental disability and restore the member to his/her best possible functional level. Comprehensive Community Support Services consist of using a variety of psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills and be provided face-to-face. Services shall be provided in accordance with applicable Kentucky Statutes and Regulations specifically 908 KAR 2:250.

Admission Criteria

- A child or adult who has a primary mental health disorder or a co-occurring mental health and substance use disorder diagnosis.

- The member requires the following support services to allow them to live with maximum independence in the community:
  - Skills training, cueing, or supervision as identified in the client's individualized treatment plan;
  - Medication adherence and recognizing symptoms and side effects;
  - Non-clinical but therapeutic behavioral intervention, support, and skills training;
  - Assistance in accessing and utilizing community resources;
  - Emotional regulation skills;
  - Crisis coping skills; and
  - Developing and enhancing interpersonal skills.

Continued Stay Criteria

- The desired outcome or level of functioning has not been fully restored or realized, improved or sustained over the time frame outlined in the individual treatment plan, OR
- The individual continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains.
- In addition, the individual has achieved current goals on their individualized treatment plan and additional goals are indicated as evidenced by documented symptoms, OR
- The individual is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the treatment plan, OR
- The individual is making some progress, but the specific interventions identified in the treatment plan need to be modified so that greater gains which are consistent with the individual's premorbid level of functioning are possible, OR
- The individual fails to make progress, demonstrates regression, or both in meeting goals through the interventions identified in the treatment plan, and the individual should be reassessed, and recommendations revised to possibly include alternative or additional services.

Discharge Criteria

- The individual's level of functioning has improved with respect to the goals/objectives outlined in the individualized treatment plan, OR
- The individual has achieved positive life outcome(s) that support stable living in the home, school, and/or community and is no longer in need of Comprehensive Community Support, OR
- The individual is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services, OR
- The individual no longer wishes to receive the service (Comprehensive Community Support).

Service Delivery

- Activities necessary to allow individuals with mental illness or co-occurring mental illness and substance use disorders to live with maximum independent in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual's treatment plan. Skills training is designed to reduce mental disability and restore the member to his best possible functional level. Consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, and medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.
- Activities should include at least one of the following services: Skills training, cueing or supervision as identified in the individualized treatment plan; Medication adherence and recognizing symptoms and side effects; Non-clinical but therapeutic behavioral intervention, support and skills training; Assistance in accessing and utilizing community resources; Emotional regulation skills; Crisis coping skills; and developing and enhancing interpersonal skills.
- Services can include teaching and modeling such skills as the following: routine household care and maintenance; activities of daily living, including personal hygiene; shopping; money management; medication management; socialization; relationship building; participation in community activities; and goal attainment.
- Comprehensive Community Support must be coordinated within the context of a comprehensive individualized treatment plan which is developed through a person-centered process. Comprehensive Community Support must be identified on each client's treatment plan as a modality to address one or more goal/objective.
- Each service provided shall be documented in the client record. This documentation shall substantiate the service provided. Documentation shall include the type of service provided, the date of service, time of service, place of service

and person providing the service. The documentation shall be signed by the person providing the service. Each Comprehensive Community Support service shall be directly related to each client's treatment plan and each service note shall reflect such.

Psychiatric Residential Treatment Facility (Level I and Level II)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) means a separate, standalone facility providing a range of comprehensive long-term, intensive treatment for children and youth under age twenty-one (21) years on an inpatient basis under the direction of a physician. The facilities provide a more highly structured environment than can be provided in a Qualified Residential Treatment Program, Residential Placement, and in the home and serves as a community-based alternative to hospitalization. The facilities also serve children and youth who are transitioning from hospitals, but who not ready to live at home or in a foster home. (42 CFR Parts 441 and 483, and 902 KAR 20:320 and 902 KAR 20:330)

Admission Criteria (Level I and II)

- The member is under age 21 with a DSM-5 diagnosis; and
- The member meets the KAR 3:130 definition of medical necessity
- Level I PRTF if the member requires:
  - Long term inpatient psychiatric care or crisis stabilization more suitably provided in a PRTF than in a psychiatric hospital; and
  - Level I PRTF services on a continuous basis as a result of a severe mental or psychiatric illness, including a severe emotional disturbance; or
- Level II PRTF care if the member:
  - Is a child with a severe emotional disability;
  - Requires long term inpatient psychiatric care or crisis stabilization more suitably provided in a PRTF than a psychiatric hospital;
  - Requires Level II PRTF services on a continuous basis as a result of a severe emotional disability in addition to a severe and persistent aggressive behavior, an intellectual disability, a sexually acting out behavior, or a developmental disability; and
  - Does not meet the medical necessity criteria for an acute care hospital or a psychiatric hospital and has treatment needs which cannot be met in an ambulatory care setting, Level I PRTF, or other less restrictive environment.

Continuing Stay Criteria

- The member is receiving active treatment
- A treatment plan has been developed and specifies:
  - The amount and frequency of services needed; and
  - The number of therapeutic pass days for a member, if the treatment plan includes any therapeutic pass days.
- A member in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the member continues to meet Level I PRTF patient status criteria.
- A Level I PRTF shall complete a review of each member's treatment plan at least once every thirty (30) days.
- The review includes:
  - Dated signatures of:
    - Appropriate staff; and
    - If present for the treatment plan meeting, a parent, guardian, legal custodian, or conservator;
  - An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
  - A statement of justification for the level of services needed including:
    - Suitability for treatment in a less-restrictive environment; and
    - Continued services.
- A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a member which shall include:
  - Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
  - An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
  - A statement of justification for the level of services needed including:
    - Suitability for treatment in a less-restrictive environment; and

        - Continued services.
- For a member aged four (4) to five (5) years, a Level II PRTF shall complete a review of the member's treatment plan of care at least once every fourteen (14) days after the initial review.
    - The review includes:
        - Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
        - An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
        - A statement of justification for the level of services needed including:
            - Suitability for treatment in a less-restrictive environment; and
            - Continued services.
- For a member aged six (6) to twenty-two (22) years, a Level II PRTF shall complete a review of the member's treatment plan of care at least once every thirty (30) days after the initial review.
    - The review includes:
        - Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;
        - An assessment of progress toward each treatment plan goal and objective with revisions indicated; and
        - A statement of justification for the level of services needed including:
            - Suitability for treatment in a less-restrictive environment; and
            - Continued services.

Discharge Criteria

- The discharge plan indicates:
    - There are member specific behavioral indicators for discharge from the service;
    - Expected service level that would be required upon discharge; and
    - Identification of the intended provider to deliver services upon discharge;
    - A crisis action plan that progresses through a continuum of care that is designed to re-duce or eliminate the necessity of inpatient services;
    - A plan for:
    - Transition to a lower intensity of services; and
    - Discharge from PRTF services;
    - An individual behavior management plan;
    - A plan for the involvement and visitation of the member with the birth family, guardian, or other significant person, unless prohibited by a court, including therapeutic off-site visits pursuant to the treatment plan; and
    - Services and planning, beginning at admission, to facilitate the discharge of the member to an identified plan for home-based services or a lower level of care.

Peer Support Services

- PEER SUPPORT is an evidence-based practice providing social and emotional support by a Peer Support Specialist in a structured and scheduled non-clinical therapeutic activity with an individual or group of members. A peer is defined as a person in recovery from a mental health, substance use, or co-occurring mental health and substance use disorder, or family member of a person living with a behavioral health or substance use disorder. The Substance Abuse and Mental Health Service Administration (SAMHSA) defines a Peer Support Specialist as an individual offering and receiving help, based on shared understanding, respect and mutual empowerment between individuals in a similar situation. Peer Support Specialist are employed by a Medicaid enrolled provider group or licensed organization and has successfully completed peer support specialist training and eligibility requirements approved by the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Types of Peer Support include:
    - Peer Support (for youth and adults) is emotional support that is provided by persons having a mental health, substance use, or co-occurring mental health and substance use disorder to others sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence-based practice. Peer Support Services are structured and scheduled nonclinical, but therapeutic activities with individual clients or groups provided by a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the client in accordance with 908 KAR 2:240.

- Family Peer Support is provided by a parent or other family member of a child who has experienced a mental health disorder, substance use disorder, or a co-occurring mental health and substance abuse disorder to a parent, guardian, or other family member with a child sharing a similar mental health disorder, substance use disorder, or a co-occurring mental health and substance abuse disorder in order to bring about a desired or personal change. A Family Peer Support Specialist is employed by a Medicaid enrolled provider group or licensed organization and shall successfully complete training and meet eligibility requirements approved by DBHDID in accordance with 908 KAR 2:230.

Service Delivery

- Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person-centered planning process and reflect the following foundational principals: recovery-oriented, person-centered, voluntary, relationship-focused and trauma-informed. The peer support services must be identified on each member's individual treatment plan and must be designed to directly contribute to the participant's individualized goals, as specified in the plan. Peer support services being provided to members in a group setting shall not exceed 8 individuals in size.
- Peer support services shall:
  - Be emotional support that is provided by:
    - An individual who has been trained and certified in accordance with 908 KAR 2:220 and who is experiencing or has experienced a mental health disorder to a recipient by sharing a similar mental health disorder in order to bring about a desired social or personal change;
    - A parent or other family member, who has been trained and certified in accordance with 908 KAR 2:230, of a child having or who has had a mental health disorder to a parent or family member of a child sharing a similar mental health disorder in order to bring about a desired social or personal change; or
    - An individual, who has been trained and certified in accordance with 908 KAR 2:240 and identified as experiencing as a child or youth an emotional, social, or behavioral disorder that is defined in the current version of the Diagnostic and Statistical Manual for Mental Disorders.
- Peer Support providers include:
  - Registered Peer Support Specialist: An applicant for registration as an alcohol and drug peer support specialist shall pay the board an initial fee for registration, and shall:
    - Be at least eighteen (18) years of age;
    - Have obtained a high school diploma or equivalent;
    - Have completed five hundred (500) hours of board-approved experience working with persons having a substance use disorder, twenty-five (25) hours of which shall have been under the direct supervision of:
      - A certified alcohol and drug counselor who has at least two (2) years postcertification experience and has attended the board-sponsored supervision training;
      - A licensed clinical alcohol and drug counselor who has at least twelve (12) months of post-licensure experience or has attended the board-sponsored supervision training; or
      - Under supervision of the board, a registered alcohol and drug peer support specialist who has at least two (2) years of post-registered experience and has attended the board-sponsored supervision training;
    - Have completed at least forty (40) classroom hours of board-approved curriculum;
    - Have passed a written examination that has been approved by the board;
    - Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;
    - Attest to being in recovery for a minimum of twelve (12) consecutive months from a substance-related disorder;
    - Have completed at least sixteen (16) hours of ethics training; three (3) hours of domestic violence training; two (2) hours of training in the transmission, control, treatment, and prevention of the human immunodeficiency virus; ten (10) hours of advocacy training; ten (10) hours of training in mentoring and education; and ten (10) hours of training in recovery support;
    - Have submitted two (2) letters of reference from certified alcohol and drug counselors or licensed clinical alcohol and drug counselors;
    - Live or work at least a majority of the time in Kentucky; and
    - Have complied with the requirements for the training program in suicide assessment, treatment, and management in KRS 210.366 and any administrative regulations.
  - Adult Peer Support Specialist - a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who provides emotional support to others with similar mental health, substance use, or co-occurring mental health and substances use disorders to achieve a desired social or personal

change. Adult Peer Support Specialist are employed by a Medicaid enrolled provider group or licensed organization and shall successfully complete training in accordance with 908 KAR 2:220.
    - Youth Peer Support Specialists - identified as experiencing as a child or youth an emotional, social, behavioral or substance use disorder that is defined in the current version of The Diagnostic and Statistical Manual for Mental Disorders (DSM). Youth Peer Support Specialist are supervised by of one of the following professionals who completed the department approved YPS 101 training:
    - physician;
    - psychiatrist;
    - advanced practice registered nurse;
    - physician assistant;
    - licensed psychologist;
    - licensed psychological practitioner;
    - licensed clinical social worker;
    - licensed professional clinical counselor;
    - licensed marriage and family therapist;
    - certified psychologist;
    - certified psychologist with autonomous functioning;
    - licensed psychological associate;
    - marriage and family therapy associate;
    - certified social worker;
    - licensed professional counselor associate;
    - licensed professional art therapist;
    - professional equivalent;
    - certified alcohol and drug counselor;
    - or psychiatric nurse.
- Individual supervision meetings must be conducted face-to-face, which includes via audiovisual telecommunications; occur no less than once a week for the first year and monthly thereafter; and be documented. The supervising professional must maintain a written record for supervision that is dated and signed by both the KYPSS and supervisor for each meeting; and includes a description of the encounter that specifies:
    - The topic discussed;
    - Any specific action to be taken;
    - An update for any issue previously discussed that required follow-up; and
    - A plan for additional training needs if any were identified.

Psychoeducation

PSYCHOEDUCATION is a direct, planned, and structured intervention that involves presenting or demonstrating information. Psychoeducation assists individuals and their families learn relapse prevention and recovery strategies, build social support, use medications effectively, cope with stress, and manage their symptoms. Psychoeducation provides individuals diagnosed with a mental health or substance use disorder and their families with pertinent information regarding the identified condition, treatment options to address the condition, and teaches problem-solving, communication, and coping skills to support recovery. The goal of psychoeducation is to help prevent relapse or development of comorbid disorders and to achieve optimal health and long-term resilience. Psychoeducation should support the individual and family in understanding these factors:

- The individual's diagnosis and symptoms
- The causes of the condition and the impact on the individual's development
- Components of treatment and the benefits of various treatment options
- Skill development to cope with the diagnosis

Service Delivery

- Psychoeducation is appropriate for individuals with mental health or substance use conditions, their families, and support networks. Psychoeducation sessions may cover topics such as understanding the nature of mental health and substance use conditions, medication management, recognizing warning signs of relapse, stress reduction techniques, and building a support network. By increasing knowledge and awareness, psychoeducation empowers individuals and families to actively participate in their treatment, make informed decisions about their care, and enhance their overall well-being.

- Covered in both individual and group formats, psychoeducation can benefit the individual diagnosed with a mental health or substance use disorder, family members, and caregivers.
- Psychoeducation is support to, and an adjunct to, actual clinical care provided by a clinician. Delivery of psychoeducation must align with a person-centered, individualized treatment plan. The rationale and indication for psychoeducation services should be reflected in the treatment plan and documented in the clinical record.
- Psychoeducation is a component of day treatment, therapeutic rehabilitation program (TRP), intensive outpatient program (IOP), partial hospitalization program (PHP), and residential services. It is included in the per diem rate for those services, and should never be billed on the same day. In addition, providers should never unbundle to separately bill for services that are bundled in the appropriate level of care.
- There is no single accepted model for Psychoeducation. Psychoeducation is a brief intervention as brevity is important when providing information, not only for engagement, but also for retention. The number of sessions usually varies from 5 to 24, with the optimum number of sessions being determined by research and practice. The sessions usually last 40-60 minutes and are mostly held at weekly intervals. The optimum number of recipients in group psychoeducation is (8) individuals. The following are essential components of Psychoeducation sessions:
  - Etiological factors
  - Common signs and symptoms
  - Awareness regarding the early signs of relapse/recurrence
  - How to cope with the situation
  - Various treatment options available
  - When and how to seek treatment
  - Need for adherence to treatment as per the guidance of treatment team
  - Long-term course and outcome
  - Dos and don'ts for family members while dealing with the recipient
  - Clearing myths and misconceptions about the illness and dispelling stigma

Psychoeducation services for various diagnoses

PSYCHOEDUCATION FOR SCHIZOPHRENIA

- Initial discussions should start by encouraging the patients to come out with their understanding of the disorder. Once this area has been clarified, a common denominator between nonexpert's knowledge of illness and scientific textbook knowledge of illness is gradually developed. The basic message should be that schizophrenia is caused by biological factors in combination with psychological stress. Hence, both medications and psychosocial interventions are essential for management. Apart from the essential components mentioned before, other information specific to the illness which needs to be shared includes
  - Meaning of the term "Schizophrenia"
  - Positive and negative symptoms
  - Neurobiological origin of symptoms
  - Stress-vulnerability-coping model
  - Various medicines and their side effects
  - Psychosocial measures
  - Psychotherapeutic interventions and suicide prevention
  - Early warning signs and relapse prevention
  - Long-term course and outcome, including remission and recovery.

PSYCHOEDUCATION FOR BIPOLAR DISORDER

- The working group on psychoeducation in bipolar disorder defines psychoeducation as information-based behavioral training aimed at adjusting lifestyle to cope with bipolar disorder. The components include increasing the awareness of illness, treatment adherence, early detection of relapse, and avoidance of potential triggers such as illegal drugs and sleep deprivation.
- Illness awareness
  - Most of the patients of bipolar disorder have poor insight into their condition. If the patient does not gain insight into his condition, he would be unlikely to take interest in the subsequent sessions of psychoeducation. Emphasizing the medical model of the illness helps in reducing stigma related to the illness. It is also taught that the illness has a biological origin, though triggering factors may be either biological or psychological.
- The issues addressed cover the following areas:
  - Introduction

- What is Bipolar Disorder?
- Etiologies and triggering factors
- Symptoms of mania and hypomania
- Symptoms of depression and mixed episode
- Course and outcome of bipolar disorder.

- Treatment Adherence
  - Almost half of the patients with bipolar disorder discontinue treatment abruptly and without supervision sometime in their lives. Almost all patients of bipolar disorder think of discontinuing medications at some point of time during the course of illness. This occurs quite commonly during the euthymic phase or in those with comorbid substance abuse or personality disorder. The areas that need to be covered while targeting better treatment adherence are as follows:
    - Mood stabilizers
    - Antimanic agents
    - Antidepressants
    - Serum levels of lithium, carbamazepine, and valproate
    - Pregnancy and genetic counseling
    - Psychopharmacology versus alternative therapies
    - Risks associated with treatment withdrawal.
  - A detailed discussion about the side effects of the commonly used medications and the ways of handling them is essential for getting rid of several myths among the patients in relation to medications. Fears of becoming “dependent for life” on these medications or “losing sharpness of mind” are some of the well-publicized misconceptions regarding
  - psychotropics which force patients to discontinue medicines abruptly. Such myths must be gradually dispelled by careful discussion.
- Avoiding substance misuse
  - More than half of bipolar disorder patients have comorbid substance abuse. Alcohol is the most frequently misused drug among bipolar patients. This is associated with more depressive episodes, greater problems with adherence, and poor recovery. Sometimes, substance use can trigger a full-blown affective episode. Psychoeducation must involve knowledge about alcohol and other drugs and their harmful effects on patients with bipolar disorder
    Detecting early warning signs is a very important step for preventing a full-blown episode. It is very important to emphasize that a hypomanic episode needs to be identified and acted upon very quickly as it may quickly escalate to a manic state. It also needs to be addressed that many patients enjoy the initial mood elevation of the hypomanic episode and hence have a tendency not to report the symptoms to family members or psychiatrists. It is also important to give the patient and family members an emergency plan of what is to be done in case of a relapse.
- Regularity of lifestyle
  - Regular habits, including proper sleep habits and structuring of activities, are emphasized. The necessity of 7–9 hours of night-time sleep is emphasized with avoidance of daytime naps is taught. The role of sleep deprivation in triggering manic episodes is also highlighted. The patients are also taught the necessity of regular physical exercise. Stress management techniques are also taught followed by simple problem-solving skills which may be of use in a day-to-day life.

PSYCHOEDUCATION FOR ANXIETY AND DEPRESSIVE DISORDERS

- Psychoeducation has become an important step in the management of anxiety and depressive disorders. After the diagnosis of anxiety and depressive disorder and performing necessary assessments, the mental health professionals should provide detailed information to the patient regarding the symptoms, causes, various treatment options, side effects of medications, need for adherence, and overall course and outcome of the disorder. Apart from medications, the role of nonpharmacological measures such as activity scheduling and regular physical exercise is emphasized. Passive psychoeducation is very popular in patients with anxiety disorders. This involves passing on to the patients’ various resources such as books, pamphlets, or videos which explain clearly various aspects of anxiety disorders. Unlike active psychoeducation, here the therapist does not interact actively with the patient while imparting education about the illness.

PSYCHOEDUCATION FOR SUBSTANCE USE DISORDER

- Group psychoeducation is one of the cornerstones of psychosocial management of patients with substance use disorder. Such groups educate patients about substance misuse and its consequences. Such groups usually deal with individuals in precontemplation and contemplation phase of change and help in increasing their motivation to abstain.

Typical group psychoeducation for substance abuse must highlight certain points which are as follows:

- Medical complications
  - Detailed discussion of physical and psychological complications is carried out. Many times, patients have wrong conceptions about physical illness, for example, they think that they are all right as long as they do not have obvious physical symptoms. Such misconceptions are cleared.
- Family issues
  - Various aspects of family problems in patients with alcohol dependence are discussed. This includes family conflicts and the role of family in maintaining substance-related behavior. How the family can help in promoting relapse prevention is also discussed.
- Social and professional aspects
  - This includes the role of peer group in initiating and maintaining substance dependence. The role of friends in promoting relapse prevention and avoiding critical comments is also discussed.
- Treatment process and recovery
  - The different phases of treatment from detoxification to relapse prevention are discussed. The role of various drugs and their side effects is discussed.
- Craving and relapse
  - In this session, the role of craving in causing relapse is discussed. This also includes the role of various triggering factors and how to avoid them. The methods of controlling craving are also discussed.
- Utilizing free time
  - The importance of finding alternate sources of pleasure is discussed along with the need to "decondition" the concept of substance with "good times" and "enjoyment."
- Adaptation to a new life
  - The patient is taught to adopt and gradually accept the new role of a "substance-free individual."

PSYCHOEDUCATION FOR PERSONALITY DISORDERS

- The primary objective of the psychoeducation program is to make the patients aware of personality disorders in general, and the particular personality disorder with which he has been diagnosed. Initially, a baseline idea regarding the patient's knowledge about his own diagnosis is obtained and what according to him would help him. The concepts of personality and personality disorder are discussed. How personality disorders can cause problems to affected individuals is highlighted. The particular personality disorder which affects the individual is discussed in detail. The patient is also encouraged to point out those features that are present in him from a written checklist consisting of various maladaptive personality traits. As psychoeducation progresses, the attempt is gradually made to make the patient aware of his maladaptive traits. Once the patient develops some insight, detailed psychoeducation of the biological and psychological factors, leading to his current maladaptive traits is carried out. However, in cases with severe personality disorders, one has to gradually work through the areas where the patient takes recourse to denial.

PSYCHOEDUCATION FOR CO-OCCURRING DISORDERS

- Dual diagnosis refers to patients having a psychiatric disorder along with comorbid substance abuse or dependence. About one-third of patients with serious mental illness has a comorbid substance use disorder. The dominant models of care for these groups of patients include parallel and sequential models. In the parallel model, separate specialists treat the comorbid disorders separately. In the sequential model, the primary condition is treated first followed by the comorbid condition. The group psychoeducation model for patients with dual diagnosis relies on an integrated holistic approach where the same team deals with the treatment of both the conditions. The main advantage of the integrated approach is that both the conditions can be given due attention in the same sitting by the same team.
- The individual or group psychoeducation programs for dual diagnosis patients must highlight the following points:
  - Stages of motivation and how to overcome the barriers to change
  - Various aspects of substance misuse and its effects on mood and behavior
  - How substance abuse adversely affects mental health and negatively alters the course and outcome of mental disorders
  - Techniques of relapse prevention and skills training
  - Ways to cope with emotional problems and symptoms of mental illness
  - Skills training and lifestyle change.

Targeted Case Management

TARGETED CASE MANAGEMENT FOR ADULTS AND CHILDREN Services furnished to assist a member in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following types of assistance:

- Targeted Case Management for Adults with Serious Mental Illness (SMI): A unit of service shall be one month; for a billable service to have occurred, at least 4 service contacts shall have occurred. Two of the contacts shall be face-to-face, which includes audio visual telecommunications, with the client. The other two contacts may be face-to-face or by telephone with or on behalf of the client.
- Targeted Case Management for Children with Severe Emotional Disorder (SED): A unit of service shall be one month. For a billable service to have occurred, at least 4 service contacts shall have occurred. Two of the contacts shall be face-to-face with the client; at least one of these contacts shall be with the child and the other shall be with the family, parent(s), or person in custodial control. The other two contacts may be face-to-face or by telephone with or on behalf of the child.

Admission Criteria (SMI/SED)

- The member is an adult diagnosed with a severe mental illness (SMI) or is a child with a severe emotional disability (SED) as defined in KRS 200.503(3);
- The member is not 21 to 64 years old while receiving services in an institution for mental disease or an inmate of a public institution;
- The member needs assistance with access to housing, vocational, medical, social, educational, or other community services or supports;
- The member has been involved with at least one child welfare agency or criminal justice agency or is in the custody of the Department of Community Based Services;
- The member is at risk of out of home placement or of inpatient mental health treatment.
- The member has been diagnosed with an SMI using the DSM-5 criteria for:
  - Schizophrenia spectrum and other psychiatric disorders;
  - Bipolar and related disorders;
  - Depressive disorders; or
  - Post-traumatic stress disorders (under trauma and stressor related disorders).
- The member's history indicates that the member exhibits persistent disability and significant impairment in major areas of community living.
- The member with SMI has had clinically significant symptoms which have persisted for a continuous period of at least 2 years; or
- The member has been hospitalized for mental illness more than once within the past 2 years; and
- The member is significantly impaired in the ability to function socially or occupationally or both.

TARGETED CASE MANAGEMENT FOR SUBSTANCE USE DISORDER: A unit of service shall be one month; for a billable service to have occurred, at least 4 service contacts shall have occurred. Two of the contacts shall be face-to-face with the client. The other two contacts may be face-to-face or by telephone with or on behalf of the client. There is a special case to this rule found in the reimbursement regulation; if the member is under the age of eighteen, contacts shall include one face-to-face with the member and one face-to-face with the member's parent or legal guardian.

Admission Criteria (SUD)

- The member has a primary moderate or severe substance use disorder diagnosis or co-occurring moderate or severe substance use disorder and mental health diagnoses;
- The member has a lack of access to the supports necessary to assist the member in the member's recovery;
- The member has a need for assistance with access to housing, vocational, medical, social, educational, or other community services and supports; or
- The member is involved with one or more child welfare or criminal justice agencies but is not an inmate of a public institution; and
- The member is not between the ages of 21 and 64 years old while receiving services in an institution for mental diseases or an inmate of a public institution

TARGETED CASE MANAGEMENT FOR INDIVIDUALS W CO-OCCURRING MENTAL HEALTH (SMI, SED) OR SUBSTANCE USE DISORDERS (SUD) AND CHRONIC COMPLEX PHYSICAL HEALTH ISSUES: A unit of service shall be one month. For a billable service to have occurred, at least 5 service contacts shall have occurred. Three of the contacts shall be face-to-face with the client. The other two contacts may be face-to-face or by telephone with or on behalf of the client. When used with clients under age 18 having SED, two contacts shall be face-to-face with the client, two contacts shall be face-to-face with parent or guardian and one face-to-face or by telephone with or on behalf of the child. This shall be delivered in accordance with the current Kentucky State Plan Amendment and Reimbursement Regulations.

Admission Criteria (Co-Occurring)

- The member is an adult diagnosed with a severe mental illness (SMI) or is a child with a severe emotional disability (SED) as defined in KRS 200.503(3);
- The member is not 21 to 64 years old while receiving services in an institution for mental disease or an inmate of a public institution;
- The member needs assistance with access to housing, vocational, medical, social, educational, or other community services or supports;
- The member has been involved with at least one child welfare agency or criminal justice agency or is in the custody of the Department of Community Based Services;
- The member is at risk of out of home placement or of inpatient mental health treatment.
- The member has been diagnosed with an SMI using the DSM-5 criteria for:
  - Schizophrenia spectrum and other psychiatric disorders;
  - Bipolar and related disorders;
  - Depressive disorders; or
  - Post-traumatic stress disorders (under trauma and stressor related disorders).
- The member's history indicates that the member exhibits persistent disability and significant impairment in major areas of community living.
- The member with SMI has had clinically significant symptoms which have persisted for a continuous period of at least 2 years; or
- The member has been hospitalized for mental illness more than once within the past 2 years; and
- The member is significantly impaired in the ability to function socially or occupationally or both.
- The member is diagnosed with a moderate or severe substance use disorder shall be a moderate or severe substance use disorder as defined in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- The member is diagnosed with A chronic or complex physical health issue shall include:
  - A cardiovascular disorder;
  - A respiratory disorder;
  - A genitourinary disorder;
  - An endocrine disorder;
  - A musculoskeletal disorder;
  - A neurological disorder;
  - An immune system disorder;
  - Obesity;
  - Cancer;
  - Deafness; or
  - Blindness.
- In addition to being diagnosed with a chronic or complex health issue, the member must also:
  - Have clinically significant symptoms which have persisted for a continuous period of at least two (2) years; or
  - Have been hospitalized as a result of the individual's physical health issue more than once within the past two (2) years; and
  - Be currently impaired in the ability to function socially or occupationally or both.
- Documentation of a member's chronic or complex physical health diagnosis that is signed and dated by a qualified medical professional shall be present in the member's medical record.

Service Delivery for All Types of Targeted Case Management

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
  - An assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that can provide needed services to address identified needs and achieve goals specified in the care plan.
- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
    - Monitoring shall occur no less than once every three (3) months and shall be face-to-face.

Targeted Case Manager Requirements

- A targeted case manager for individuals with SMI, SED, or SUD shall:
  - Possess a bachelor of arts or science degree in a behavioral science;
  - Be a certified alcohol and drug counselor who has a bachelor of arts or science degree;
  - Have provided targeted case management services to a recipient any time from April 1, 2014, to the effective date of this administrative regulation; or
  - Have supervised the provision of targeted case management services to a recipient any time from April 1, 2014, to the effective date of this administrative regulation;
  - Have at least one (1) year of full-time employment experience after completing the educational requirements:
    - Working directly with adults in a human service setting; or
    - Working directly with individuals under the age of twenty-one (21) in a human service setting;
  - Successfully complete a department approved targeted case management training within six (6) months of employment as a targeted case manager; and
  - Successfully complete department approved continuing education requirements every three (3) years thereafter.
- A master's degree in a behavioral science may substitute for the one (1) year of full-time employment experience required by subsection (3)(b)1 of this section.
  - A targeted case manager for individuals with SMI, SED, or SUD and a co-occurring chronic or complex physical health condition shall be an individual with:
    - A master's degree in a behavioral science from an accredited college or university and two (2) years of full-time employment experience providing service coordination or linking/referring for community based services for individuals with SMI, SED, or SUD and co-occurring physical or behavioral health disorders or multi-agency involvement; or
    - A bachelor of arts or science degree from an accredited college or university in a behavioral science and who has:

        - At least five (5) years of full-time employment experience working with an individual with SMI, SED, or SUD and a co-occurring chronic or complex physical health condition;
        - Successful completion of a department approved targeted case management training within six (6) months of employment as a case manager; and
        - Successful completion of continuing education requirements every three (3) years thereafter.
- Targeted case managers who are serving individuals with SED, SMI, or SUD shall have:
    - Individual face-to-face supervision which shall be provided at least monthly for at least one (1) year by a behavioral health professional who has completed the targeted case management training approved by the department; and
    - Group supervision which shall be provided at least monthly for the duration of employment as a targeted case manager.
- The supervisor of a targeted case manager shall maintain documentation of the supervision.
- Targeted case managers who are serving an individual with an SED, SMI, or SUD and a co-occurring chronic or complex physical health condition shall have:
    - Individual supervision which shall be provided at least three (3) times per month, with at least two (2) of these supervisory contacts on an individual face-to-face basis, for at least three (3) years by a behavioral health professional who has completed the targeted case management training approved by the department; and
    - Group supervision which shall be provided at least monthly for the duration of employment as a targeted case manager.
- Beginning October 1, 2015, a targeted case manager shall not exceed a case load size of twenty-five (25) unique clients receiving any service, excluding a client receiving mobile crisis services, crisis intervention services, or screenings.
- A targeted case manager shall:
    - Only provide targeted case management services to the targeted population for which the targeted case manager meets the educational, experiential, and training requirements; and
    - Not provide other behavioral health services in addition to targeted case management services for the same client.

Targeted Case Manager Training Requirements

- To receive certification to provide behavioral health targeted case management services, a targeted case manager shall successfully complete the department approved training and continuing education requirements established by this section.
    - The core components of the targeted case management training curriculum shall be at least twelve (12) hours and shall include:
        - Core targeted case management functions and guiding principles;
        - Engaging consumers and family members;
        - Behavioral health crisis management;
        - Strengths-based case management;
        - Ethics;
        - Behavioral health diagnosis and understanding treatment;
        - Integrated care;
    - Advocacy skills and empowering consumers and families;
    - Cultural awareness;
    - Developmental perspectives across the life span; and
    - Documentation and billing.
        - At least an additional six (6) hours of specialized training for the target population the targeted case manager is serving, which shall include the skills required to address the specific needs of each respective target population.
        - Providers of approved training curricula shall notify the department within twenty (20) business days of a trainee's successful completion of a targeted case manager training.
- A targeted case manager shall complete continuing education requirements every three (3) years.
- Required continuing education shall consist of acquiring at least six (6) hours of relevant continuing education each year in training topics directly related to:
    - Case management;
    - Behavioral health; or
    - Each respective target population.
- A targeted case manager shall submit a list of all continuing education trainings in which the targeted case manager participated, the provider or presenter of the training, and the number of hours of each training to the Department every

three (3) years through the department's Web site. The submission due date shall be the last day of the month of which the targeted case manager's initial certification was completed.
- Targeted case managers certified prior to the effective date of this administrative regulation shall submit documentation of continuing education hours prior to May 2018.

Therapeutic Rehabilitation Program

THERAPEUTIC REHABILITATION PROGRAM is a rehabilitative service for adults with a severe mental illness or children with a severe emotional disability designed to maximize reduction of the effects of a mental health disorder and restoration of the recipient's best possible functional level. Services shall be designed for the reduction of the effects of a mental disorder related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his or her own rehabilitation goals within the person-centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills (hygiene, meal preparation, and medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

THERAPEUTIC REHABILITATION SERVICES FOR ADULTS

A therapeutic rehabilitation program of a community mental health center is a goal-oriented service for persons with SMI which provides a therapeutic program for persons who require less than twenty-four (24) hours a day care but more than outpatient counseling. Therapeutic rehabilitation shall be an effective intervention, the purpose of which is to assure that a person with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn, and work in his own environment.

Services shall be designed for the development, acquisition, enhancement, and maintenance of interpersonal, personal adjustment, and daily living skills. The focus of all services shall be on helping clients to develop and maintain a healthy self-esteem. Clients shall be encouraged to retain the fullest possible control of their daily lives, to set their own rehabilitation goals, and to participate fully in decisions affecting their own lives and future.

THERAPEUTIC REHABILITATION SERVICES FOR CHILDREN

Children’s therapeutic rehabilitation program shall be a goal-oriented program for children under age twenty-one (21) who have a mental health diagnosis as established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, and who require more than intermittent outpatient services.

Children’s therapeutic rehabilitation services may be provided twelve (12) months a year. Individual, group, and family therapies and collateral services may be provided in addition to the therapeutic rehabilitation services.

Admission Criteria

- Member adults with SMI, Children with SED who require less than 24-hour care but more than outpatient counseling.

Continued Stay Criteria

- Member adults with SMI or Children with SED continue to require a therapeutic program less than twenty-four (24) hours a day but more than outpatient counseling.

Discharge Criteria

- Member adults with SMI or Children with SED no longer want, require or need a therapeutic program less than twenty-four (24) hours a day care but more than outpatient counseling.
- When symptom reduction indicates a lesser level of care.

Service Delivery

- Treatment plans should be developed through a person-centered planning process. Goals and objectives should be individualized.
- The need for this level of intervention shall be identified by the appropriate mental health center staff and shall be indicated in the treatment plan.

- A weekly summary note shall be used to document billable services. Staff notes shall be written by the person providing the service and cosigned, when appropriate. The weekly summary note shall reflect the goals and objectives identified in the treatment plan. In addition, it shall include an objective description of the individual's attitude, a reaction to treatment, progress, behavior, suggested changes in treatment, and other information as deemed relative. A description of the activities and how the activities were used to facilitate psychiatric therapy shall also be included.
- Treatment plans shall be reviewed and updated by staff at least every three (3) months.
- These services shall be provided by:
  - A licensed psychologist;
  - A licensed professional clinical counselor;
  - A licensed clinical social worker;
  - A licensed marriage and family therapist;
  - A physician;
  - A psychiatrist;
  - An advanced practice registered nurse;
  - A licensed psychological practitioner;
  - A licensed psychological associate working under the supervision of a licensed psychologist;
  - A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;
  - A certified social worker working under the supervision of a licensed clinical social worker;
  - A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist;
  - A physician assistant working under the supervision of a physician;
  - Under CMHCs psychiatric nurses and professional equivalents could also provide this service.

Best Practices and Program Principles

- Principle 1: Psychiatric rehabilitation practitioners convey hope and respect and believe that all individuals have the capacity for learning and growth.
- Principle 2: Psychiatric rehabilitation practitioners recognize that culture is central to recovery and strive to ensure that all services are culturally relevant to individuals receiving services.
- Principle 3: Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision-making and facilitate partnerships with other persons identified by the individual receiving services.
- Principle 4: Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.
- Principle 5: Psychiatric rehabilitation practices are person-centered; they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.
- Principle 6: Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.
- Principle 7: Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.
- Principle 8: Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.
- Principle 9: Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.
- Principle 10: Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.
- Principle 11: Psychiatric rehabilitation services emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.
- Principle 12: Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

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Revision History

Date	Summary of Changes
01/2021	Version 1
01/2022	Version 2
01/2023	Version 3
01/2024	Version 4: Annual Review

2/18/2025	Annual Review:
	• Psychoeducation services added; effective 01/01/2025.
	• Recommendations per State feedback:
	  ○ Clarification of Peer Support Specialist role
	  ○ Clarification that face-to-face services include audiovisual telecommunications
	  ○ Added Targeted Case Manager education requirements, training requirements

06/20/2025	Interim Review Updates from the State: • Removal of annual limitations for Peer Support Services and Psychoeducation • Added ACT services and LOCUS criteria information. • Optum approval on 5/20/2025 • State approval 06/20/2025