ADAMH

Alcohol, Drug and Mental Health Board
of Franklin County

BUDGET INSTRUCTIONS

Contract Year 2021

I. ALLOCATION & CLIENTS

A. Overview

The intent of this worksheet is to identify the Provider's total allocations, how those allocations correspond to the KY20 projected encounter values and projected expenses, and how many unique clients are expected to be served by each allocation.

All allocations have been categorized as either "Required" or "Exempt" block grants or Central Pharmacy.

ADAMH will be transitioning to "fixed rates" for all services in 2021. Note that the encounter value (volume of encounter claim units x unit rate) of each allocation will not necessarily equal a provider's cost/expense but should align closely to the allocation amount (+/- 10%).

Cells highlighted in yellow and green will require Provider data entry.

B. Field Descriptions

Column A **Provider** lists the name of the Provider.

Column B **Allocation Type** identifies whether the allocation pertains to Central Pharmacy or is managed as a block grant.

Column C **Allocation Line** identifies the allocation's System of Care category. All allocations have been categorized as Crisis, Family Supports, Housing, Prevention, Recovery Supports, or Treatment,

Column D **Allocation SubType** identifies the purpose of the allocations that are exempt from encounter claiming. Allocations that require encounter claiming in Smartcare do not have SubTypes.

Column E **Encounter Claim Status** indicates whether the allocation requires encounter claiming in Smartcare or is exempt from encounter claiming.

Column F **120 Day Notice** identifies the allocation that have a special set-aside. If an allocation has a "yes" in this column, Providers should refer to the notice emailed on 9/17/20.

Column G **KY21 Allocation** identifies the initial allocation amounts as approved by the ADAMH Board of Trustees for KY21.

Column H **Projected Encounter Value** identifies the encounter claims the Provider anticipates earning for each allocation. For budgeted allocations, the Projected Encounter Value will be determined by a formula that references cells in the budget worksheets for each of the six System of Care categories. Projected Claims for non-budgeted programs

(i.e. block grants exempt from requiring encounter data and Central Rx) are populated with "N/A".

Column I **Projected Expense** will need to be entered (cells highlighted in yellow) by the Provider to reflect the projected expenses for all Block Grants and Central Pharmacy. Data in this column should reflect what Providers anticipate to spend for each allocation, regardless of claiming activity. Projected expenses should only reflect costs associated with ADAMH-paid services (should not include Medicaid, commercial insurance or other grant funding).

Column J **Projected Unrealized Allocations** calculates the variance between annual allocations (Column G) and projected expense (Column I). If a Provider is proposing a shift between allocations on the "Proposed SOC Shifts" worksheet, the proposed shift should align with the variances indicated in this column.

Column K **Projected Clients** will need to be entered (cells highlighted in yellow) by the Provider to show the number of unique ADAMH-funded clients that are anticipated to be served by each allocation.

C. Provider Action Required

1. After completing the budget worksheets for the System of Care categories, review the calculated Projected Encounter Value (Column H) for accuracy.

2. Enter the Projected Expense (Column I) for Central Pharmacy allocations.

3. Enter the Projected Expense (Column I) for Block Grant allocations.

4. Enter the count of unique ADAMH-funded clients (Column K) that are anticipated to be served by each allocation.

II. CRISIS, FAMILY SUPPORTS, HOUSING, PREVENTION, RECOVERY SUPPORTS, AND TREATMENT SYSTEM OF CARE WORKSHEETS

A. Overview

A separate budget worksheet has been provided for each System of Care (SOC) category that relates to a Provider's allocations. Some Providers will have six (6) worksheets while others may have only one.

The intent of these worksheets is to quantify service mix and volume for each SOC category. For each SOC category a combination of Allocation Transition Groupings (services where a group member was previously used) and procedure codes may be required.

Each procedure code used in SHARES has been cross walked to a procedure code to be used in SmartCare. Some procedure codes have been consolidated (from many in SHARES to one in Smartcare). If a Smartcare procedure code is listed multiple times and is aligned to the same Allocation Transition Grouping, then the Provider only needs to enter projected units for one instance of the code. Many unit definitions have been converted from Client to 15 Minutes. Unit rates have been standardized and cannot be customized for individual providers.

Performance Incentive codes do not require a projected unit volume to be entered.

B. Field Descriptions

Column A **Provider** lists the name of the Provider.

Column B **System of Care Category** identifies which of the six (6) System of Care categories pertains to that procedure code. Note that procedure codes can only be assigned to one SOC category.

Column C **Allocation Transition Grouping** identifies a "program" or "population" that was historically used to manage allocations in SHARES. An Allocation Transition Grouping is assigned to all instances where a group member was previously used in SHARES, but the naming convention is now more generalized. The implementation/use of this field in Smartcare is still being evaluated, but this structure should facilitate the transition between the two enterprise systems.

Column D **SHARES Code** lists the corresponding 5-digit SHARES code that were used to submit claims in Contract Year 2020. SHARES codes are either derived from national code sets or proprietary to the SHARES system (codes that start with Z****). Codes in this column will NOT be used in 2021 but have been added as a crosswalk indicator between SHARES and Smartcare.

Column E **SHARES Procedure Code Description** lists the corresponding SHARES procedure code description that were used to submit claims in Contract Year 2020.

Column F **SmartCare Code** lists the corresponding 5-digit procedure code that will be used to submit claims in Contract Year 2021. SmartCare codes are either derived from national code sets or proprietary to the SmartCare system (codes that start with Z****). ADAMH will also begin using Ohio's BH Redesign code set for Medicaid-eligible services.

Column G **SmartCare Procedure Code Description** lists the corresponding SmartCare procedure code description that will be used to submit claims in Contract Year 2021. Note that select BH Redesign codes have different rates based only on the rendering provider(s). ADAMH has created unique groupings for each of these instances and added additional context in the description field. For example, Psychotherapy (90832) does not have either unique modifiers or place of service to differentiate the unit rate. The rate differentials are only based on the rendering provider.

SmartCare Code	Mod1	Mod2	SmartCare Procedure Code Description	Rate
90832			Psychotherapy, 30 minutes (Dr.)	$66.27
90832			Psychotherapy, 30 minutes (Ind. Professionals)	$56.32
90832			Psychotherapy, 30 minutes (General Supervision)	$47.88

Column H **Mod 1** is the modifier in position one and will be used for select Medicaid-eligible services (replicates BH Redesign).

Column I **Mod 2** is the modifier in position two and will be used for select Medicaid-eligible services (replicates BH Redesign).

Column J **Medicaid Eligible? Y/N** identifies if a SmartCare procedure code is deemed eligible for Medicaid reimbursement by ADAMH.

Column K **SmartCare Unit Definition** states the unit definition for each SmartCare procedure code.

Column L **2021 Unit Rate** lists the SmartCare encounter value rate for Contract Year 2021. Unit rates have been standardized and cannot be customized for individual providers.

Column M **2021 Projected Unit Volume** must be completed by the Provider to show anticipated service volume for each procedure code.

Column N **Projected Encounter Claim Value** is calculated as the product of the 2021 Unit Rate (Column L) and the 2021 Projected Unit Volume (Column M).

C. Provider Action Required

1. Review worksheet for accuracy and to understand the "mechanics" of how ADAMH allocations are earned in the SmartCare environment.

2. Enter the anticipated 2021 Projected Unit Volume (Column M) for each procedure code. Review the Projected Claims for each allocation (refer to "Allocations and Clients" worksheet). The projected claim volume for each allocation is NOT required to match the allocation but should reflect the Provider's best estimate of projected service activity for KY 2021.

3. Enter projected client counts as the 2021 Projected Unit Volume (Colum M) for procedure code Z0000. Each System of Care category that includes an Allocation Transition Grouping is paired with a line item for Z0000. Z0000 is a placeholder and has no financial impact on the budget. Instead, Z0000 will be used to budget project client counts for each Allocation Transition Grouping within a System of Care Category. ADAMH will notify Providers prior to the beginning of the year if Z0000 codes will be actively utilized in SmartCare.

III. PROPOSED SOC SHIFTS

A. Overview

ADAMH recognizes that the KY21 allocations may need to be realigned for various reasons.

For example, in the transition to BH Redesign some providers may find that their service mix (procedure codes) is inconsistent with the current allocations. This worksheet enables providers to identify shifts that ADAMH should consider.

Please note that all shift requests must net to $0.

B. Field Descriptions

1. FROM – Allocation Line – to identify the allocation line that is requested to be reduced

2. FROM – Allocation SubType – to identify the allocation subtype that is requested to be reduced, if applicable (exempt block grants only)

3. FROM – Amount – the requested reduction amount

4. TO – Allocation Line – to identify the allocation line that is requested to be increased

5. TO – Allocation SubType – to identify the allocation subtype that is requested to be increased, if applicable (exempt block grants only)

6. TO – Amount – the requested increase amount

C. Provider Action Required

1. Compare the Projected Expenses on the Allocations and Clients tab to current Allocations to evaluate if proposed shifts are needed.

2. For requested shifts, provide the Allocation Line, Allocation SubType, and Amount for the reduction and increase (making sure the net change is $0).

PLEASE ADD A BRIEF NARRATIVE EXPLAINING THE PROPOSED SHIFT IN ALLOCATIONS.