



Making the Decision to Become a CMA or AMH+

What are the benefits of becoming a CMA or AMH+?

The benefits of becoming a CMA will vary depending on your agency; this will be determined by the market in your region, the members you serve, and the services you provide. Remember that care management is a function, not a service.

What should our organization consider in making the decision to become a CMA or AMH+?

- How many members does your organization serve? Would you have enough members to support a care team?
- Does your organization currently use an electronic health record (EHR)? (An EHR is required to become a CMA.)
- Does your organization have a plan to utilize a care management platform (CMP)? (A CMP is required to implement care management.)
- Does your organization have the infrastructure to add care management functions (hiring resources, IT resources, etc.)?
- Can you calculate a return on investment (ROI)? How many members would we need to break even? How many to have a profit?
- Is your organization geographically located in a saturated market? Does your geographic region need CMAs?
- What are your relationships with other entities (hospitals [behavioral health and physical health], SU facilities, primary care physicians [PCPs], other agencies, etc.)?
- Does your organization already have internal staff who could fill the required roles?
- What is your location hiring market like?
- Do you know how this team would fit in your organization?
- Does your organization have access to clinical consultants, i.e. PCPs, psychologists, specialists?

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What organizational standing/experience is needed to become a CMA or AMH+?

Relevant experience

- Your organization must be able to demonstrate that your past experience positions you to provide Tailored Care Management (TCM) to the Behavioral Health and Intellectual/ Developmental Disabilities Tailored Plan population (specifically the subpopulation(s) for whom you propose to become a certified TCM provider).
- If your organization specializes in behavioral health, you must have the capacity to serve populations with both mental health and substance use needs.
- Your organization must offer an array of services that are aligned with the needs of the target populations in North Carolina.
- Your organization must be able to show at least a two-year history of providing services to the Behavioral Health I/DD Tailored Plan population in North Carolina.

Provider relationships

- Your organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant behavioral health, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provider formal and informal feedback and opportunities to share best practices.
- Your organization must have one or more contracts, memorandums of agreement (MOAs) or formal relationships in place with organization an in a category that is outside your organization's designation, across behavioral health, I/DD, primary care, and social services.
- Three contracts, MOAs, or formal relationships is preferred in order to be fully compliant with the state's expectation.
- Your organization needs to have a concrete and clear plan to strengthen and formalize relationships with specific providers across behavioral health, I/DD, primary care, pharmacy, social services, and/or other community resources.

Capacity and financial sustainability

Your organization must have the capacity and financial sustainability to establish care management as an ongoing line of business, and to operate Tailored Care Management on a long-term basis. This includes, at minimum:

- A recently audited financial statement/report that demonstrates capacity for ongoing operation at or above current levels of services volume (e.g., days in accounts receivable/payable, at least 60 days of cash on hand).
- A billing, accounting, and reporting system in place that aligns with the department's and Behavioral Health I/DD Tailored Plan requirements.

Your organization must have the following components in place by the time of program launch:

- GAAP balanced budget, positive fund balance and 60 days of cash on hand.
- An organizational chart that indicates who is responsible for budget and financial management.
- A clear understanding of where Tailored Care Management fits into the organization (e.g., title of the executive who will have accountability for Tailored Care Management, supervisory structure for care management, key nonclinical supporting staff identified).
- For all populations for which the organization has applied to provide Tailored Care Management, evidence that the organization has considered whether the Medicaid client volume for the age(s)/disability(ies) applied for is enough to sustain the service line for the organization.
- YTD statement of operations and financial projections for 2022 and 2023.
- Rationale for updates to projected population or service volumes that impact revenues or expenses.
- Summary of how capacity-building funds will be used to fill gaps (e.g., staffing, HIT) by Tailored Care Management launch.
- Board member and/or executive-level support of the budgetary and financial management plans.

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Oversight

Your organization must demonstrate that you have the appropriate structures in place to oversee the Tailored Care Management model, including a strong governance structure. Examples of strong governance structure include:

- A governing board and bylaws are in place.
- There is a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest.
- A chart showing relationships among senior executive/management leadership.
- Documentation that describes how these relationships correspond to Tailored Care Management (e.g., who will supervise the care management team, who will provide close oversight of the Tailored Care Management program during startup and on an ongoing basis, etc.).

References:

- NC DHHS Desk Review Guide and Evaluation Tool – Category 2: Organizational Standing/Experience Tailored Care Management Provider Manual, Section V, Part 2.
- NCQA AMH+/CMA Certification Site Review Protocol.