



Learning Community Framework

**Financial Management of Prospective Payment &
Value-Based Reimbursement**

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Welcome



North Carolina CCBHC Pilot



Track 2 Focus: Leadership Readiness & Financial Sustainability



Wi-Fi | Restrooms | Agenda-at-a -Glance

Opening & Introductions



Welcome



Introductions



Why We're Here
Today

Purpose & Objectives Of Track 2



Build leadership clarity & readiness



Strengthen financial sustainability thinking



Prepare for PPS realities



Apply, not just learn

How Today Will Be Different

Applied, not lecture-
based

Real-world decisions

Peer learning

Coaching and dialogue



Use microphones when speaking



Ask questions anytime



Virtual participants: chat + Q&A



Respectful, practical dialogue

Participation Expectations

Morning Session:

Leadership Clarity & Readiness

10:10 AM – 12:00 PM

Setting The
Foundation:
What A CCBHC Is (And
Is Not) In North
Carolina



Federal Intent Of The CCBHC Model



National standard for community behavioral health



Comprehensive, accessible services



Whole-person, integrated approach



Cost-based reimbursement

CCBHC In North Carolina: Key Framing



State implementation of a federal model



Adapted to NC Medicaid environment



Trillium Pilot

Site-Based Certification

Certification is **location-based**

Not organization-wide

Leadership choice: *which* site(s)

Scope & Location Considerations

What services are delivered at the CCBHC site vs. CCBHC community locations

What is provided via partners (Designated Collaborating Organizations)

Geography and access

CCBHC & Tailored Care Management

Complementary, not duplicative

Distinct roles

Coordination expectations

The Nine Required CCBHC Services

Crisis services (24/7)

Screening & assessment

Person-centered planning

Outpatient MH & SUD (medication mngt)

Case management

Psychiatric rehabilitation

Peer & family supports

Primary care screening & monitoring

Text Goes Here

Standardized national behavioral health model

Core Characteristics Of A CCBHC

Comprehensive scope
of required services

Access regardless of
ability to pay

Whole-person and
integrated care

Accountability for
outcomes and quality

24/7 crisis response capacity

Clinical & Access Characteristics

Same-day or rapid
access expectations

Evidence-based
practices

Person- and family-
centered treatment
planning

Use of peers and lived
experience

Operational & Governance Characteristics

Site-based certification

- Governance structure
- Formal partnerships and MOUs
- Cultural and linguistic competence
- Continuous quality improvement processes
- Data and performance transparency

CBHC governance model options

- 51% of BOD is people with lived experience & family members or
- Advisory committee that reports to BOD

Financial & Payment Characteristics

Prospective Payment System (PPS)

- Cost-based rate development
- Defined scope discipline
- Annual cost reporting
- Alignment of operations and reimbursement

CCBHC vs. Traditional Behavioral Health Clinic






Traditional Clinic

- Limited-service scope
- Office-hour access
- Fee-for-service driven
- Variable care coordination
- Often siloed programs
- Payment tied to volume

CCBHC Model

- Comprehensive required scope
- 24/7 crisis access
- PPS, cost-based payment
- Formal care coordination
- Integrated MH, SUD, crisis
- Accountability for outcomes

What Leaders Often Underestimate In The CCBHC Model

-  The magnitude of culture change required (not just compliance)
-  The time and discipline needed to redesign access and workflows
-  The operational lift of clean data, encounters, and cost reporting
-  The effort required to make partnerships actually work
-  The leadership courage needed to stop delivering misaligned services

Services Excluded From PPS

**Tailored Care
Management**

**Most NC enhanced
services excluded**

**Stays longer than 24
hours, (Facility-Based
Crisis Center (FBCC))**

Financial Sustainability Is A Leadership Issue



Driven by decisions



Not just finance



Structure matters



Key Financial Drivers In NC



Access design



Staffing model



Volume



Cost control



Data accuracy





Leadership Decisions That Matter

- Who you serve
- Speed of access
- Role design
- What you stop doing



PPS1 vs PPS2 – Strategic Framing

- PPS1: daily rate
- PPS2: monthly rate
- Readiness matters

Eligible Populations For PPS



Medicaid Direct



Tailored Plans



Dual eligibles (with limits)

Shared Patients & Member Fluidity

Normal reality

Billing complexity

Location-based logic

What Leaders Must Anticipate

Data discipline

Encounter definitions

Staffing impacts

Partner alignment

Morning Takeaways



Clarity
Gained



Decisions
Surfaced



Afternoon Will
Pressure-Test

Lunch Break

12:00 PM – 1:00 PM

Afternoon Session:

Scenario-Based Leadership

1:00 PM – 3:55 PM

Why Scenario Building

Leadership decision-making tool

- Speed, prioritization, and tradeoffs
- Pressure-testing assumptions

How We Will Work Today

Organizational leadership teams

- Real, time-bound scenarios
- Limited resources and imperfect data
- Leadership moves—not full plans
- Parallel virtual facilitation

Retail provider enters your market



Commercial volume drops quickly



2–3 months of financial runway

Scenario 1: Market Disruption

What is the primary threat?

Which services are most at risk?

What reactions should be avoided?

Scenario 1: Leadership Analysis

30 to 90-day leadership moves



Strategic repositioning



Differentiation through complexity and access



Alignment with CCBHC strengths

Scenario 1: Decision Focus

Scenario 2: Workforce Pressure

Flat reimbursement

- Hiring and retention challenges
- Overtime leading to burnout

Scenario 2: Leadership Analysis

Which staffing assumptions no longer hold?

- What leadership behaviors reinforce the problem?
- Are licenses used appropriately?

Scenario 2: Decision Focus

Role and care model redesign

- Service prioritization or reduction
- Peers, technology, alternatives
- Productivity and scheduling changes

Scenario 3: Rural Sustainability

Reduced funding for rural clinics

Commitment to rural access

Current model loses money

Scenario 3: Leadership Analysis

What does 'keeping clinics open' mean?

What must remain local?

What can be centralized or shared?

Hub-and-spoke models

Shared services and centralization

Virtual care and regional staffing

Redefined onsite scope

Scenario 3: Decision Focus

Scenario Synthesis

External pressures emerge quickly



Workforce, market, and finance are linked



Focused leadership beats reactive tactics



Leadership Takeaways

Which decisions must accelerate?

- Which assumptions need revisiting?
- Leadership under uncertainty

Integrated Q&A

3:00 PM – 3:45 PM

Open, moderated discussion

- In-person and virtual participation
- Scenario-based questions encouraged

Anticipated Q&A Topics

PPS1 vs PPS2 readiness

- Shared patients
- Workforce redesign
- Rural access strategies
- Pilot timing and readiness

Closing Reflections

Leadership judgment matters



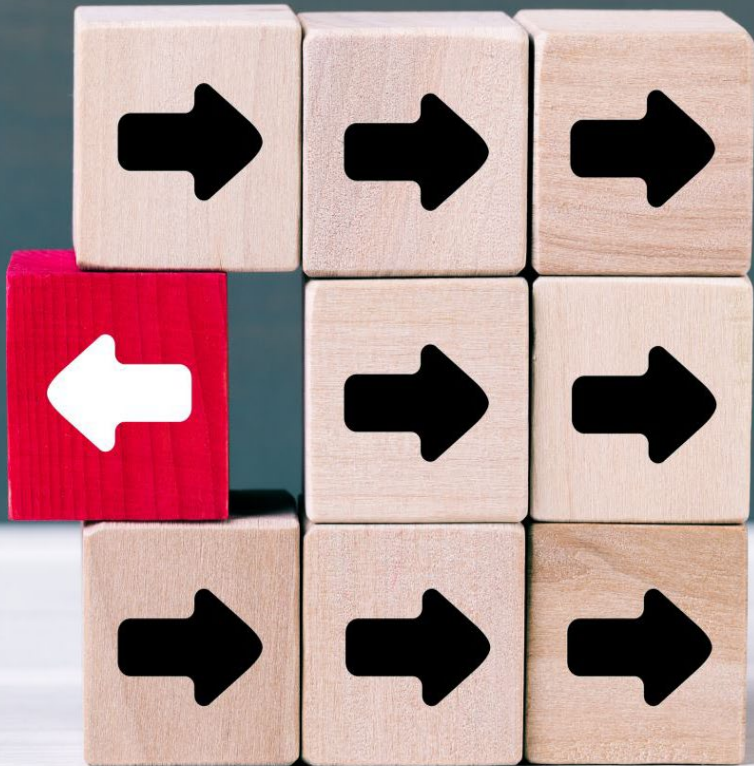
Decisions under pressure



CCBHC opportunity and responsibility



Commitments & Next Actions



One near-term decision

- One managed risk
- One follow-up action

Thank You

Appreciation for participation

- Follow-up supports available
- Session adjourned

