Proposed significant changes for 2026 CCO contracts

The items below have been submitted by OHA units/programs as proposed significant changes for the 2026 CCO contracts. Approval decisions about most changes will be made in May, following presentations to CCOs and Medicaid leadership. Decisions about some financial items will be made in the summer, after OHA's 2025-27 budget is approved by the Legislature.

Please note that the list below does not include significant changes that may result from bills under consideration in the current legislative session. The effect of signed bills on the 2026 contracts will be confirmed in the summer.

FINANCIAL

1. Risk Corridors	
• Potential removal of existing Handicapping Malocclusion risk corridor. (Medicaid) • Potential removal of existing Mobile Crisis risk corridor. (Medicaid) • Simplify existing Healthier Oregon Program risk corridors. (Medicaid & Non-Medicaid)	
2. Directed Payments (all 3 contracts)	
• Behavioral Health: Changes to or removal of existing behavioral health directed payments. Specific changes depend on rate setting process and available funds. • Dental: Changes to or removal of existing dental directed payments. Specific changes depend on rate setting process and available funds. • Maternity: Add new directed payment for maternity rates at rural hospitals. This directed payment may be separate payment term (ie, outside of capitation payments like existing Hospital and Ground Emergency Medical Transportation directed payments). This directed payment is tentative and still contingent on Governor's Office, legislative, and federal approvals. • Graduate Medical Education: Add one-time directed payment to expand GME payments. Focused on resident physicians in rural hospitals that don't receive GME from current program. This directed payment may be separate payment term (ie, outside of capitation payments like existing Hospital and Ground Emergency Medical Transportation directed payments). This directed payment is tentative and still contingent of Governor's Office, legislative, and federal approvals. • Culturally & Linguistically Specific Services: Expand existing CLSS directed payment depending on rate setting and available funds.	
3. HRSN Climate Non-Risk to Risk Corridor (Medicaid & Non-Medicaid)	Replace existing method of paying CCOs for Climate-Related Supports on non-risk basis (reimbursed at FFS rates, with settlement process) with including funding in capitation rates, with risk corridor
4. HRSN Admin Settlement Removal (Medicaid & Non-Medicaid)	Remove HRSN administrative settlement.
5. MLR Incentive Payment Due Date (Medicaid)	Require CCOs to submit their quality incentive payment data by December 1st as supplement to Minimum Medical Loss Ratio Rebate Report due by August 31st.

REQUIRED

6. Overpayments (Medicaid)	Add new federal requirement for CCOs to report identified and recovered overpayments to the state within 30 days. Specify method for overpayment reporting and define term 'identified overpayment' for the purpose of this reporting requirement.

7. Referencing WCAG 2.2 in All Contracts (all 3 contracts)	Require CCOs to comply specifically with Web Content Accessibility Guidelines 2.2 (Levels A and AA) for digital communications with members, including websites, apps, and documents. Contract currently refers to WCAG 2.0 and successor versions as one of several types of applicable modern accessibility standards. *This change has been identified as a prerequisite for the following content under consideration for possible inclusion in 2027 contracts*: Ensure that most current recommended standard for accessibility, WCAG 2.2 (Levels A and AA), is met by requiring documentation of accessibility conformance and practices, including the submission of Accessibility Conformance Reports.
8. FQHC RHC Encounter Data (all 3 contracts)	Prohibit CCOs from requiring FQHCs and RHCs to use OB global billing codes as they don't include all codes for which providers are eligible to receive supplemental payments from OHA as required by Social Security Act.
9. BHP Quality and Performance Monitoring (BHP)	Add all sections of Exh B, Pt 10 (Transformation Reporting, Performance Measures and External Quality Review) in Medicaid Contract to BHP Contract, except for quality pool incentive payment content. Required to comply with federal regulations for BHP.
10. 7-day authorization timeline (all 3 contracts)	Update prior authorization timeframe for standard requests from 14 to 7 calendar days per federal requirement.

WAIVER-RELATED (Medicaid & Non-Medicaid)

11. HRSN CIE Requirements	Allow CCOs to require HRSN Service Providers to use Community Information Exchange for Closed Loop Referrals, with certain exceptions for providers as specified OHA guidance.
12. HRSN Housing Transition and Moving Costs	In certain cases of domestic violence and for accessibility reasons: Allow housing benefit to be covered at different member address. Expand housing benefit to cover certain moving expenses.
13. HRSN Pantry Stocking Benefit	Require Pantry Stocking Benefit be administered solely through EBT card used for SNAP.
14. HRSN Fruit and Vegetable Benefit	Require CCO to have at least one local produce HRSN Nutrition Provider or Vendor within their Nutrition Fruit & Vegetable Benefit structure.

REQUIRED & WAIVER-RELATED

15. Reentry Health Care (Medicaid)	Identify CCO pre-release and post-release care coordination and administrative responsibilities (as distinguished from OHA FFS responsibilities) for new Reentry Health Care benefits for incarcerated individuals. Benefits based on Section 5121 of federal Consolidated Appropriations Act (2023) and Reentry Demonstration under 1115 Medicaid Waiver.

DISCRETIONARY

16. NEMT Program Improvements (all 3 contracts)	Require NEMT Rider Guide to be standalone document, no longer allow option to be in either Member Handbook or Rider Guide. Add "exhibits chronic lateness" as a required service modification per CMS guidance. Require communication devices to allow driver to communicate in rider's spoken or

	signed language for members with limited English or who have hearing/speech impairment.
17. Final HEP Report and NCQA HE Accreditation (Medicaid)	Provide details about the final health equity report submission. Change due date for 2026 Health Equity Plan. Expand role of CCO Health Equity Administrator. Add requirements and due dates for CCOs to receive accreditation by NCQA for health equity. *This change has been identified as a prerequisite for the following content under consideration for possible inclusion in 2027 contracts:* All CCOs must be accredited by NCQA for health equity.
18. SHARE Program Changes (Medicaid)	Replace Spending Plan with Attestation. Require CCOs to publicly post SHARE investments instead of OHA posting the info. Clarify and further define 25% set-aside flexibility. Define carry-forward flexibility.
19. Sickle Cell Therapy Carve-Out (all 3 contracts)	Carve-out for cell and gene therapy (CGT) for sickle cell disease included in CMS CGT Access Model. Costs for CGT product (Lyfgenia and Casgevy) covered directly by OHA FFS; CCOs responsible for all other associated costs.
20. Language Access Improvements (all 3 contracts)	TBD for changes resulting from OHA's internal Language Access Audit.