2026 BEHAVIORAL HEALTH DIRECTED PAYMENT

CCO REQUIREMENTS AND OHA GOVERNANCE

Purpose:

This brief clarifies what Coordinated Care Organizations (CCOs) are required to do under the 2026 Behavioral Health (BH) Directed Payment policy. It is intended to help providers and CCOs understand the parameters of the policy and distinguish between required actions and areas open to negotiation. This is not legal advice.

Overview

Oregon's behavioral health system continues to face high demand and evolving needs. To better support this landscape, Oregon Health Authority (OHA) is refining its Behavioral Health Directed Payment (BHDP) policy for Calendar Year 2026 (CY26). These changes aim to:

- Focus limited resources on providers delivering team-based care to members with complex needs.
- Provide greater flexibility to CCOs in structuring provider contracts.
- Maintain financial support for behavioral health services through updated capitation rates.

What's Changing in 2026: Directed Payments Focused on Team-Based Care

In 2025, CCOs were required to pay 110% of the OHP open card rate, or their past reimbursement level, to most BH providers with over 50% Medicaid revenue. In 2026, this requirement applies only to providers who qualify as Team-Based High Acuity Medicaid Providers.

Who Qualifies for Enhanced Payments in 2026

To qualify in 2026, a provider must either:

A. Be a Community Mental Health Program offering: Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), or Intensive In-Home Behavioral Health Treatment (IIBHT)

OR

B. Meet all of the following:

1. Hold a Certificate of Approval from OHA.
2. Derive ≥50% of BH service revenue from OHP members.
3. Deliver integrated, team-based care including (as clinically indicated):
    - On-staff or contracted psychiatric or addiction medicine provider
    - Integrated peer support
    - Case management services
    - Community-based services (individual, group and family therapy)

WHAT'S STAYING THE SAME

- **CLS and COD Payments**: Culturally and Linguistically Specific (CLS) Services and Co-occurring Disorder (COD) enhanced payments will continue unchanged in 2026.

- **OHA Cannot Mandate Rates**: Without CMS-approved directed payments, OHA cannot intervene in rate negotiations between CCOs and providers. The 2026 BH directed payment proposal is subject to approval by CMS each year.

What CCOs *Are* Required to Do

In Calendar Year 2026 (CY26) CCOs are required to:

- **Continue CLSS and COD Payments:** Culturally and Linguistically Specific Services (CLSS) and Co-occurring Disorder (COD) enhanced payments will continue unchanged in 2026. This means that all providers who meet these criteria for these services will receive the enhanced payment for these services. To learn more about these enhanced payments, please click here.
- **Pay Enhanced Rates to Eligible Providers:** Beginning in 2026, CCOs must pay at least 110% of the OHP open card rate *only* to behavioral health providers who qualify as Team-Based Care Medicaid Providers, as defined by OHA. This will include providers such as community mental health programs, medium and large behavioral health providers, safety net providers, etc.
- **Use the 2026 Directed Payment Guidance:** CCOs must follow the updated 2026 BH directed payment guidance and provider attestation (to be released by OHA) to determine which services and providers qualify. The key highlights of this are that the higher rates are directed toward providers with the ability to deliver a team-based model of care to include, as clinically indicated, therapy, psychiatric or addiction medicine services, peer support and case management.
- **Apply Enhanced Payments Only if CMS Approves:** The team-based care requirement is still pending federal approval. If CMS does not approve the 2026 directed payment preprint, CCOs will not be required to make enhanced payments. Historically, OHA has heard from CMS by the end of the calendar year or early in the actual rating year. If OHA gains approval after January 1, 2026, it will be retroactive back to the beginning of 2026.

What CCOs Are *Not* Required to Do

In CY26, CCO are not required to:

- **Pay Enhanced Rates to All BH Providers:** Unlike in 2025, CCOs are ***not*** required to pay 110% of the OHP open card rate to all BH providers with over 50% Medicaid revenue. This requirement is narrowed in 2026 to only those meeting the team-based care criteria. What this means is that CCOs will be able to negotiate the actual payment rate for all services with these providers and there is no floor in the payment (for providers not meeting the new criteria). These negotiations are not overseen by OHA and are between the CCO and the provider.
- **Maintain 2025 Payment Structures:** CCOs are not obligated to maintain 2025 payment arrangements for providers who no longer qualify under the 2026 criteria. These providers do not have a payment floor anymore and are subject to negotiated rates with CCOs.
- **Bring OHA into individual negotiations:** OHA cannot intervene in rate negotiations between CCOs and providers. For providers that meet the team-based requirements that do not feel a CCO is meeting their CMS-approved directed payment, OHA can work to hold the CCO accountable to meet the direct payment requirements.

Provider Negotiations & CCO Responsibilities for Network Adequacy

CCOs are responsible for negotiating with providers to build an adequate network:

- **Network Adequacy Requirements:** CCOs must ensure timely and geographically reasonable access to behavioral health services. This includes:
  - Meeting time and distance standards based on member location and provider type.

- Submitting network adequacy reports to OHA demonstrating compliance with access standards.
- Ensuring access to integrated and coordinated care, including primary care and behavioral health services.
- Ensuring access to required programs such as ACT, IIBHT, Supported Employment, crisis services.

- **Encouragement of Value-Based Payments (VBPs):** OHA strongly encourages CCOs to move away from fee-for-service models and toward value-based payment arrangements that reward quality, outcomes, and equity rather than volume; support team-based, whole-person care, especially in behavioral health; ensure viability for some specialized programs; and include infrastructure payments and shared savings/risk models for advanced care delivery systems. Note that OHA cannot require specific payment models.
- **Quality Incentive Program (QIP):** CCOs can earn bonus payments by meeting or exceeding performance targets on a set of state-defined quality measures and are encouraged to have correlative agreements with their provider network. Metrics and performance targets include behavioral health access and engagement, which requires a robust behavioral health network. The number and focus of these targets are set by the Metrics & Scoring Committee, not by OHA.

Key Takeaways

The following are key takeaways related to the CY26 BH Directed Payment changes:

- **CCO rates for 2026 built to meet growth in costs**: While CCOs received increases in their overall 2026 rates, the cost drivers and overall utilization trends will make negotiations with all providers difficult. The BH directed payment was pared down to reflect this challenge and allow for the enhanced payments to go to the providers that provide team-based care.

- **Flexibility for CCOs**: The 2026 BH Directed Payment changes give CCOs more flexibility to design payment models that reflect local needs and provider capacity.
- **Pending CMS Approval**: The new directed payment structure is not final until approved by CMS. Until then, no new payment requirements apply. If CMS does not approve, CCOs will not have a minimum for these eligible providers and contracts are subject to CCO negotiation.

Next Steps

The following are key milestones related to the CY26 BH Directed Payment program:

Milestone	Timeline
CMS application for 2026 BH directed payment submitted	Submitted October 2025
CY2026 CCO capitation rates submitted to CMS	November 2025
Updated 2026 BH Directed Payment Guidance released	December 2025
Updated Provider Attestation for Team-Based Care released	December 2025
BH Provider Webinar	December 5, 2025

OHA will notify all interested parties once CMS issues a final decision on the 2026 directed payment proposal. Please reach out to the OHA Actuarial Services team with any questions at Actuarial.Services@odhsoha.oregon.gov.