BEHAVIORAL HEALTH TEAM BASED CARE DIRECTED PAYMENT GUIDANCE

The Centers for Medicare and Medicaid Services Medicaid managed care regulations at 42 C.F.R. § 438.6(c) govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. The Oregon Health Authority (OHA) implemented multiple directed payment (DP) programs in 2023 in the Coordinated Care Organization (CCO) contracts that further the goals and priorities of the Agency.

The DPs covered in this guidance document apply to the 2026 Medicaid, Non-Medicaid, and OHP Bridge-Basic Health Program Contracts. This document provides guidance on policy, operational, and rate-setting considerations.

In the 2026 Medicaid Contract, which is the primary CCO contract, these payments are referred to as “Qualified Directed Payments (QDPs) within CCO Payment Rates” and covered in Exh. C, Sec. 1, Para. d, Sub.Para. (2). The DP requirements in the Medicaid Contract are incorporated by reference in both of the other contracts in Exh. C, Sec. 1, Para. d, Sub.Para. (1), Sub-Sub.Para. (a-f).

Capitalized terms not defined in this document have the meanings assigned to them in the CCO contracts. If the term “Member” is qualified, by referencing one specific CCO contract, it means the guidance applies to only those Members covered under that specific CCO contract and not any of the Members covered under the other two contracts. For example, if this document uses the term “Medicaid Member,” then the guidance only applies to Members covered under the Medicaid CCO contract and does not apply to Members under the non-Medicaid or Basic Health Program Contract.

Note that recent updates to the contracts resulted in deleting the directed payment obligations for services provided to HOP members and members with standalone Title XXI coverage (Children's Health Insurance Program). However, CCOs may, but are not required to, mirror the directed payment amounts for services received by these individuals.

For 2025 OHA required a payment increase for contracted “Primarily Medicaid” Behavioral Health (BH) providers. “Primarily Medicaid” was defined as the Provider having at least fifty percent (50%)

of its total patient service BH revenue derived from providing services to OHP Members in the prior Contract Year.

For 2026, this DP has been revised with additional requirements for a Provider to qualify to receive at least 110% of current FFS rates effective on 1/1/26. Providers can meet the requirement in one of two ways:[1]

- CMHPs that provide ACT/SE, IIBHT and/or EASA automatically qualify and do not need to submit an attestation to qualify.
- Or Providers must meet all three of the following criteria to be eligible:
  1) Hold a certificate of approval from OHA; and
  2) At least fifty percent (50%) of their total patient service BH revenue derived from providing services to OHP Members in the prior Contract Year; and
  3) Can deliver team-based care to include all the following, as clinically indicated:
     a) Psychiatric services and/or addiction medicine services
     b) Peer delivered services (CRM, PWS, PSS)
     c) Case management services
        i) Individual, group and family community-based services.

A Provider entity that directly employs individuals providing the above listed services as part of an integrated team meets these requirements. In addition, Providers contracting with psychiatric providers, addiction medicine providers, and peer delivered service providers also fulfill the above requirements. Contracted services must demonstrate timely access to all services based on clinical indication. Team-based providers must work off the same service plan and clinical record. Attestations of team-based care and meeting access goals will be monitored by CCOs through network agreements.

WHAT SHOULD YOU DO?

Providers:

1. Each contracted BH Provider should assess whether they meet the above criteria and if so, gather financial information to demonstrate their distribution of BH revenue for patient services attributable to OHP Members and to patients covered by other payers against their total BH revenue for services provided in 2025. If the Provider believes they qualify as a Team-Based Provider, then they should use this financial information to complete the BH Provider attestation. The BH Provider attestation template is available on the CCO Contract Forms webpage. In addition, the attestation form includes a section to attest to meeting the team-based care and Certificate of Approval criteria.

   The Provider must submit the completed attestation to each CCO with which they contract, along with any supporting documentation as may be required by each CCO. The completed attestation is the official confirmation that each CCO is required to have in their records under their OHA contracts.

CCOs:

1. Each CCO must work with its BH Participating Providers to establish that the individual Providers qualify for the directed payment. CCOs should work with providers to ensure that any providers delivering ACT, SE, EASA, IIBHT or who are a CMHP are automatically enrolled in directed payments. Upon acceptance of the completed BH Provider attestation (and any required supporting documentation) that supports qualification as a team-based care provider, each CCO must pay the applicable DP rate for 2026 dates of service[2] as follows:

   - Effective January 1, 2026, if the 2026 attestation (and documentation) was received prior to that date (if early submission is allowed by the CCO) or on any date through March 31, 2026.

   - Effective on the 1st day of a subsequent calendar quarter if the 2026 attestation (and documentation) was received on any date in that quarter. For example, if the Provider's submission is received on August 1, 2026, then the DP rate is retroactive to July 1, 2026, as the 1st day of the July-September calendar quarter.

[2] Since the DP rate applies only to contracted BH Providers, the effective date for the DP rate cannot be earlier than the effective date of the Provider's contract, regardless of when the CCO receives the Provider's 2026 attestation (and documentation).

2. By March 31, 2026, each CCO must provide OHA with a written attestation of compliance with all 2025 DP requirements, including BH Primarily Medicaid. OHA will post the attestation template on the CCO Contract Forms webpage by December 31, 2025.
3. CCOs that utilize Alternative Payment Methodologies (APMs) may continue to use such arrangements but must demonstrate and document that the APM incorporates the directed payment increase.

APPENDIX A — CATEGORY OF SERVICE (COS) CROSSWALK

OHG DESCRIPTION	CLAIM TYPE	COS			
			TEAM	COD	CLS
PROF-MH-ABA-SERVICES	Professional	ABA			X
PROF-MH-ACT	Professional	ACT/SE	X		X
PROF-MH-SUPPORT-EMPLOYMENT	Professional	ACT/SE	X		X
OP-MH-OTHER	Outpatient	MH Services Non-Inpatient	X	X	X
PROF-MH-ALT-TO-IP	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-ASSESSMENT-EVALUAT	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-CASE-MANAGEMENT	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-CASE-MGT	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-CONSULTATION	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-CRISIS-SERVICES	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-EVAL-MGMT-PCP	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-INTERP-SERVICES	Professional	MH Services Non-Inpatient	X	X	
PROF-MH-MED-MGT	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-MST	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-OP-THERAPY	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-PDTS	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-PHYS-OP	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-PRTS-CHILD	Professional	MH Services Non-Inpatient	X		
PROF-MH-RESPITE	Professional	MH Services Non-Inpatient	X	X	
PROF-MH-SKILLS-TRAINING	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-SUBACUTE	Professional	MH Services Non-Inpatient	X		
PROF-MH-SUD-UNBUCKETED	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-SUPPORT-DAY	Professional	MH Services Non-Inpatient	X	X	X
PROF-MH-THERAPY	Professional	MH Services Non-Inpatient	X	X	X

OHG DESCRIPTION	CLAIM TYPE	COS			
			TEAM	COD	CLS
PROF-MH-THERAPY-INPATIENT	Professional	MH Services Non-Inpatient	X	X	
PROF-MH-UNBUCKETED	Professional	MH Services Non-Inpatient	X	X	X
PROF-PHYS-OTHER-E-M-MH	Professional	MH Services Non-Inpatient	X	X	X
PROF-PHYS-PRIMCARE-E-M-MH	Professional	MH Services Non-Inpatient	X	X	X
PROF-PHYS-SOMATIC-MH	Professional	MH Services Non-Inpatient	X	X	X
OP-CD-A	Outpatient	SUD	X	X	X
OP-CD-B	Outpatient	SUD	X	X	X
PROF-MH-WRAPAROUND-SERVICE	Professional	MH Children's Wraparound			X
PROF-CD-ASSESS-SCREENING	Professional	SUD	X	X	X
PROF-CD-METHADONE-AMH	Professional	SUD	X	X	X
PROF-CD-METHADONE-TREAT	Professional	SUD	X	X	X
PROF-COMMUNITY-DETOX	Professional	SUD	X	X	X
PROF-SBIRT-A	Professional	SUD	X	X	X
PROF-SBIRT-B	Professional	SUD	X	X	X
PROF-SUD-UNBUCKETED	Professional	SUD	X	X	X
PROF-CD-RES-ADULT	Professional	SUD Residential		X	X
PROF-CD-RES-CHILD	Professional	SUD Residential		X	X
THW PROCEDURE CODES (NEW THW OHG UNDER DEVELOPMENT)					X

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