2026 OHP funding and CCO contract renewal

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Why are "sustainable" rates important?

Sustainability means sufficient to maintain access to health care.

- Reduces uncertainty and confusion among Oregon Health Plan members seeking care
- Increases certainty and confidence in the Oregon Health Plan by the medical community
- Allows CCOs to plan for community benefit and value based payment arrangements
- Sets a foundation on which state can collectively address challenges with H.R.1
- Accounts for cost shifting impacts

Why are 2026 rates insufficient?

Historical & structural underfunding

- Repeated single-digit rate increases despite double-digit cost growth
- 3.4% growth rate not meant to be permanent (2024 was 3.1%)
- Per-member-per-month (PMPM) underfunding leads to greater overall losses as enrollment grows
- Unfunded mandates and policy changes strain resources
- Administrative costs often excluded or underestimated in rate setting
- FFS benchmarks drive CCO rates, but timelines are often misaligned
- External & uncontrollable cost drivers: out-of-state and cost based hospitals; behavioral health utilization increases; and benefit "scoping"

Current situation grew over time

- Years of piecemeal legislation seeking to increase provider reimbursement
- Ongoing administrative burden reforms in process or proposed
- Costs rising across all insurance markets, not just Medicaid
- Medical Loss Ratios (MLRs) now exceed 95% in some cases
- Reductions in Quality Improvement Program (QIP) funding

Persistent challenges in CCO rate setting

Revenue does not match size and cost of the program – rate set at wrong amount

Rate-setting process transparency

- General state-wide assumptions are opaque
- Regional trends or variation between CCOs are not shared
- Proprietary models cannot be independently validated
- Impacts of new benefits or mandates are not transparently priced
- Limited ability to provide input
- Need for year-over-year consistency and alignment with actual cost growth

CCO tools to manage costs have been curtailed

- Moved from 3-year to 1-year medical loss ratio
- Payment rates and included providers increasingly mandated
- QIP cuts reduce our tools for improving health outcomes
- Transition of Prioritized List from waiver to next iteration creates benefit coverage uncertainty

Opportunities for improvement

- **Primary question for the executive and legislative branch:** How do we ensure a better overall process and methodology to ensure we don't end up here again year after year?
- QIP and investment strategy
  - retroactive funding cut
  - provider timeline of 11 months of work
  - drive better outcomes and savings
- Leading into HR 1: Shifted risk but didn't address cost drivers
- Need to sustain coordinated care model: FFS is more expensive and less integrated than CCO model

Questions?

Thank you!

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