

Other formats and languages

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact CCO Operations at CCO.Ops@odhsoha.oregon.gov or 503-508-5872 (voice/text). We accept all relay calls.

Memorandum

To: Coordinated care organizations (CCOs)

From: David Inbody, CCO Operations director

Date: Oct. 16, 2026

Subject: Care Coordination Data Guidance for the Healthier Oregon Transition

This memo provides guidance to CCOs on Oregon Health Authority's (OHA) expectations of each CCO related to:

- Roles of CCOs, OHA, and Acentra Health for the purposes of care coordination and transition of care.
- How CCOs are expected to facilitate a transition-related warm handoff.
- How CCOs will need to manage referrals to Acentra Health when members are identified outside of the timeframes for the three data reports.
- What care coordination data CCOs will need to send to OHA to support transition of care and when and how CCOs will need to submit this data.

This is the third of four guidance memos about data submissions required to support member transitions to the Oregon Health Plan (OHP) Open Card program effective Jan. 1, 2027. Other memos in this series are

- Non-emergent medical transportation,
- Health-Related Social Needs (HRSN), and

- Prior authorization (coming soon).

Why is this happening?

Oregon Administrative Rule (OAR) [410-141-3850](#) for Transition of Care was updated effective Oct. 1, 2026, through the temporary rulemaking process. The rule provides OHA with the right to issue additional guidance to CCOs to facilitate member transitions that involve 500 or more members.

What should you do?

Review OHA's guidance and expectations below and ensure care coordination for each Healthier Oregon member transitioning to OHP Open Card aligns with this guidance.

Transition of care roles for CCOs, OHA and Acentra Health

CCOs:

- Identify and deliver member details for a subset of Healthier Oregon members who need more support through the transition, using the guidance and definitions in this document. (OHA refers to these members as a “priority population” in this memo and the [Tier 2 reporting template](#).)
- Participate in transition warm handoff meetings scheduled by Acentra Health.
- Ensure CCO members and providers are aware of care coordination expectations and requirements. This includes:
 - Identifying members for warm handoffs,
 - Facilitating warm handoffs between CCO and Acentra Health, and
 - Providing Acentra Health with necessary information and referrals to preserve continued access to care.

OHA:

- Provide guidance and reporting specifications to CCOs,
- Receive data delivered by the CCO to the specified OHA platform, and
- Deliver the information to the appropriate teams (including Acentra Health) for the purposes of care coordination.

Acentra Health:

- Receive data delivered by OHA, as well as between-reporting referrals (as described below) and
- Use the data for the purposes of care coordination.

Transition warm handoff meetings

For this requirement, a transition warm handoff means a transition meeting attended by the Predecessor Entity (CCO) and the Receiving Entity (OHA). At this meeting, the CCO transfers the responsibility of member's ongoing care to Acentra Health for continuity of care and care coordination services. The transition meeting may be completed virtually.

CCOs will provide the appropriate contacts for scheduling these meetings in the "Instructions" tab of the [reporting template](#) under "primary care coordination contact" and "back up care coordination contact" fields.

CCOs and Acentra Health may choose to structure meetings as appropriate for the time and effort needed to facilitate the transition (e.g., multiple meetings for all members, one meeting for all members, one meeting for each member).

To prepare for the warm handoff meetings, CCOs may choose to use a clinical SOAP note (Subjective, Objective, Assessment, Plan), SBAR (Situation, Background, Assessment, Recommendation), or another format that, at a minimum, includes the following information for each member:

- Reason for care coordination or case management
- Current services and supports (e.g., primary care providers, specialty providers, community supports)
- Current care plan goals (if applicable)
- Outstanding needs/barriers
- Risk and safety considerations
- Member engagement level
- Any other relevant information not listed above, as applicable

Referrals

CCOs may identify times they need to send a referral to Acentra Health outside of the [Tier 2 timeframes listed below](#). CCOs may

contact Acentra Health via secure email ORCM@acentra.com to request a warm handoff meeting or to share member needs using templates below.

Instructions for sending a secure email to schedule a warm handoff meeting:

- Subject: Warm Handoff: Care Coordination HOT Member
- De-identified member need (primary diagnosis, need, safety considerations, urgency, etc.)
- CCO Care Coordinator name and contact information

Instructions for sending a secure email to share member information:

Subject: Handoff: Care Coordination HOT Member

I am reaching out to facilitate a handoff for [Member Name], who is transitioning from [CCO Name] care coordination/case management to Open Card (FFS) care coordination/case management.

- Member information (Name, ID)
- Primary diagnosis/condition(s)
- Why ongoing care coordination or case management is needed
- Safety considerations
- Immediate follow-up, such as those listed below:
 - New provider needed
 - Medication continuity review
 - Treatment/procedure coordination
 - DME/vendor transition
 - Member outreach required
 - Urgent action needed
- Pending prior authorizations, if applicable
- Priority Flag
 - YES – Risk of interruption to life-sustaining, lifesaving, or life-altering care
 - NO – Standard transition.
- Provider Information
 - Provider Name (First name, last name)

- Provider Type (ex: PCP)
- Key Medications/DME ordered (ex: Oxygen, Insulin)

[CCO Care Coordinator Name]

[Title]

[CCO]

[Phone Number]

[Email Address]

How and when CCOs must submit transition of care data

To provide care coordination data to OHA, CCOs must use the two reporting templates provided by OHA.

- Tier 1 and Tier 2. Completed templates and all supporting documents (Care Plans, Health Risk Assessments in PDF format) must be submitted to OHA via managed file transfer (MFT) no later than 11:59 p.m. on the due dates listed below.
- Refer to [MFT upload process](#) for additional instructions on how to access the MFT.

CCOs will provide Acentra Health the appropriate contacts for technical or data-related questions in the “Instructions” tab of the [reporting template](#) under “primary care technical contact” and “back up technical contact” fields.

Tier 1 Data: Due/submitted on October 1

Tier 1 data contains Healthier Oregon members in care management for planning purposes. On Sept. 8, 2026, OHA provided CCOs with a template for sharing these data. Tier 1 data was due Oct. 1, 2026, via MFT.

Tier 2 Data: Due November 6, December 8 and January 7

Tier 2 data contains members in care management and members in other priority populations identified by OHA. OHA shared a draft template with CCOs for sharing these data on Aug. 19, 2026. [The final Tier 2 reporting template](#) includes more detailed data elements such as:

- The priority population(s) a member belongs to,
- Contact information, and
- Other details essential to their care coordination.

CCOs will submit Tier 2 data three times as part of the transition. Each data transfer should represent the CCO's full list of Tier 2 members as of each submission date. This means that CCOs may report the same member(s) during each Tier 2 data transfer.

If CCOs have reported a member in Tier 2 data transfers, CCOs only need to upload the member's Care Plans or Health Risk Assessment documents if they have changed since the previous upload.

Table 1. Tier 2 Data due dates and transfer method

CCOs must upload all requirements listed below to the MFT/MOVEit server no later than 11:59 p.m. on the designated dates. Files must use the [naming conventions](#) listed below.

Due date	Reporting Due	Method
Friday, Nov. 6, 2026	• Tier 2 reporting template, • Care Plan PDFs, • Completed Health Risk Assessment (HRA) PDFs (as applicable)	MFT
Tuesday, Dec. 8, 2026	• Tier 2 reporting template, • Care Plan PDFs, • Completed HRA PDFs (as applicable)	MFT
Between Dec. 8, 2026, and Jan. 1, 2027	• Referrals, as applicable	Secure email or request for warm handoff meeting
Thursday, Jan. 7, 2027	• Tier 2 reporting template, • Care Plan PDFs, • Completed HRA PDFs (as applicable)	MFT

Naming conventions

CCOs must use naming conventions for files according to instructions below.

Tier 2 Reporting Template:

Acentra_HOT_CCO_CC_filename_date.xlsx

- Example:
Acentra_HOT_Trillium_CC_prioritypopulation_20261102.xlsx

PDF documents (Care Plans and Health Risk Assessments):

MedicaidID_Acentra_HOT_CCO_CC_lastname_firstname_original filename_date.pdf

- Example:
abcd1234_Acentra_HOT_Trillium_CC_smith_smurf_careplan_20261117.pdf

MFT upload process

- Save all files using the naming conventions listed above.
- Upload the file to the Incoming MFT/MOVEit server, also known as the Actuarial MFT.
- The Office of Health Policy and Analytics will monitor data delivered on this date and deliver it to the appropriate teams for the transition.

Priority Populations to be identified by CCOs (see Tier 2 Template for definitions, including code lists):

- 1) Currently receiving care coordination or case management (CM)
- 2) Members who are pregnant
- 3) Organ transplant members
- 4) Members of any age requiring prescription liquid nutrition or receiving medical grade formula
- 5) Members approved for or receiving mental health (MH) residential services
- 6) Members approved for or receiving substance use disorder (SUD) residential services
- 7) MH crisis intervention services
- 8) Intensive In-Home Behavioral Health Treatment (IIBHT) or Multisystemic therapy (MST)
- 9) Enrolled in Early Assessment and Support Alliance (EASA)
- 10) Members who are currently hospitalized
- 11) Members approved for/receiving radiation or chemotherapy
- 12) Members on dialysis
- 13) Members currently receiving flexible services
- 14) Members currently receiving Lieu of Services (ILOS)
- 15) Assertive Community Treatment (ACT)
- 16) Members receiving Post-Hospital Extended Care (PHEC) services

- 17) Other: Members who need additional care coordination or case management but do not fall into any other category listed above. CCOs can provide details on these members in the “Other” field in the reporting template.

Priority Populations to be identified by OHA/ODHS

OHA is identifying members in areas where data is more readily accessible to OHA/ODHS, including those in:

- Wraparound services,
- Medically fragile children,
- Community restoration,
- Children with high medical complexity based on the Pediatric Medical Complexity Algorithm (PMCA),
- Oregon State Hospital (OSH),
- Long Term Services and Supports (LTSS),
- Intellectual and Developmental Disabilities (IDD),
- Machine/electric dependency, and
- Young Adults with Special Health Care Needs.

OHA is identifying these members to ensure complete identification of priority populations. However, CCOs must **not** exclude members in these populations if they also fall into any population required for CCO Tier 2 data reporting. CCOs must report data for all members described above.

OHA expects to share this information with Acentra Health along the same timelines as CCO reporting.

OHA also plans to schedule a technical coordination meeting between Acentra Health and the CCOs, after the initial file transfer so that any questions about the data are resolved.

Acentra requirements

- Tier 2 data: Acentra Health will receive all CCO and OHA data via MFT and ingest into their system of record.
- Warm handoff meetings: Acentra Health will schedule and facilitate all meetings with CCOs. Acentra Health will use the CCO contact list provided by CCOs to schedule meetings.
- Secure emails from CCOs: Acentra Health will contact each CCO timely, as member’s circumstances require, to either schedule

warm handoff meetings or acknowledge receipt of the handoff information.

Questions?

For questions about this guidance, please email Marci Howard, at marci.howard@oha.oregon.gov.

For questions about the data templates and reporting, please email Sofia De Anda at sofia.de-anda@oha.oregon.gov .

For questions about the Healthier Oregon transition, please email Stephen White, CCO Services Manager, at stephen.c.white@oha.oregon.gov.

Thank you for your continued support of the Oregon Health Plan and the services you provide to our members.

Disclosure

This guidance is meant to accompany the CCO contracts and applies to the transition of care as stated in OAR 410-141-3850. This guidance memo may be updated from time to time, and as such, the version reflected on the CCO Contract Announcements [web page](#) is the most up to date, with the last revised date noted.