



OREGON
HEALTH
AUTHORITY

Instructions for
Care Coordination Report

Background

Oregon Administrative Rules (OARs) 410-141-3500, 410-141-3860, 410-141-3865, 410-141-3870 and 42 CFR 438.208 requires Coordinated Care Organizations (CCOs) implement procedures to deliver care to and coordinate services for all CCO enrollees.

This document provides reporting instructions for the bi-annual Care Coordination Report (CCR) referenced in Exhibit B, Part 2, Section 8, Paragraph a, Sub Paragraph 3 of the 2025 CCO Contract and OAR 410-141-3860 (9).

Instructions for Care Coordination Report

CCOs must submit the Care Coordination Reports twice a year on the due dates listed below. Of note, the data report is due twice a year, but the data must be disaggregated by quarter in two separate files. This applies to all members, regardless of plan type (CCOA, CCOB, CCOE, CCOF, CCOG), except FFS. If a member changes CCOs, report the data you have. If you are unable to report on a specific element, indicate N/A.

Reporting Periods	Report Due Date
Q1 and Q2 2025 (January 1 – March 31, 2025 and April 1 – June 30, 2025)	October 24, 2025
Q3 and Q4 2025 (July 1 – September 30, 2025, and October 1 – December 31, 2025)	February 14, 2026

Care Coordination data files may be submitted in any of the following file formats:

- ASCII text file*
- Comma-separated values file (CSV)*
- Spreadsheet file (e.g., Excel)
- Other file types as coordinated with OHA

***OHA prefers large data submissions via ASCII text file or Comma-separated values file (CSV).**

The report templates are located on the [CCO Contract Forms page](#). Bi-annual submissions should be sent via the [Contract Deliverables portal](#). (The submitter must have an OHA account to access the portal.)

If you have questions or concerns about completion of the templates or submitting to the OHA, please email HSD.QualityAssurance@odhsoha.oregon.gov for technical assistance. Please use “Care Coordination” in the subject line so the email is routed correctly.

Member Risk Stratification Log:

This log is a transaction level report of all members and their risk stratifications during the reporting period. List all members enrolled in the CCO at any point during the reporting period. This includes new members who started their enrollment during the reporting period as well as members continuing enrollment. Include the baseline risk stratification level of each member and their updated risk stratification level(s). If a member changes risk stratification levels throughout the time period, list each change on a separate line along with the date of the risk stratification level.

Data Field Name	Data Field Description	Data Field Instructions	Required
Client ID	Member's 8-digit alphanumeric Oregon Health Plan ID number.	Enter the Member's 8-digit alphanumeric Oregon Health Plan ID number. For any/all members currently or newly enrolled in the reporting period. Do not enter a CCO or Provider ID number. Format/Value: 8-digit alphanumeric value (e.g., AZ19936X).	Yes
Risk stratification occurred during the reporting period	Did risk stratification occur during the reporting period?	Enter Yes (Y) if it did or No (N) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes
Baseline risk stratification	Baseline Risk stratification level of the member as of 1/1/2025, or the member's first stratification anytime in the reporting period if they were not enrolled as of 1/1/2025.	Enter the risk stratification level of the member: 0 = No or low risk; or Only Invalid Diagnosis; or Healthy Users 1 = Moderate risk 2 = High risk or Very High Risk. <i>Note: If baseline is reported in Quarter 1, leave this field blank in Quarter 2 reporting.</i>	Yes

		Note: This includes both algorithm and subjective risk stratification. Format/Value: numeric values 0, 1, or 2 only	
Date(s) risk stratification changed	Date(s) the members risk stratification changed.	Enter date the CCO completed risk stratification of the member when the risk stratification level changed. Note 1: If risk stratification changed multiple times within the reporting period, record each instance on a separate line. Note 2: If a member was not risk stratified during the current reporting period, then please leave the field Blank. Format/Value: MM/DD/YYYY (e.g., 01/01/2025).	Yes - Required if risk stratification changes occurred during the reporting period.
Risk stratification level changes	Risk stratification level of the member.	Enter the risk stratification level of the member only when their level changed. 0 = No or low risk; or Only Invalid Diagnosis; or Healthy Users 1 = Moderate risk 2 = High risk or Very High Risk Format/Value: numeric values 0, 1, or 2 only	Yes - Required if risk stratification occurred during the reporting period = 'Y'.

LTSS/SHCN/HRCC and Service Usage Log

List all individuals who were enrolled in the CCO at any time during the reporting period. This includes both new enrollees who began during the period and those with ongoing enrollment. In accordance with

OAR 410-141-3865(3)(g), document the Health-Related Circumstance Changes (HRCCs) for each member, indicate whether they belonged to any special population groups, and note any use of identified services during the reporting period. Data instructions vary by element, please ensure data is reported as requested (i.e. date format, Y/N, diagnosis code, etc.).

Data Field Name	Data Field Description	Data Field Instructions	Required
Client ID	Member's 8-digit alphanumeric Oregon Health Plan ID number.	Enter the Member's 8-digit alphanumeric Oregon Health Plan ID number. For any member currently or newly enrolled in the reporting period. Do not enter a CCO or Provider ID number. Format/Value: 8-digit alphanumeric value (e.g., AZ19936X).	Yes.
Care Plan	Date a care plan was developed or updated.	Enter the date a care plan was developed or updated. If care plans were developed or updated multiple times within the reporting period, record each instance on a separate line. Format/Value: MM/DD/YYYY (e.g., 01/01/2025). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	Yes, when applicable.
Long Term Services and Supports (LTSS) needs identification	Please indicate if the individual has been identified as having LTSS needs as defined by OAR 410-120-0000 (180).	Enter Yes (Y) if the individual has been identified as having LTSS needs or No (N) if not. <i>Note: Use data from either reports received</i>	Yes.

		<i>from Aging and People with Disabilities (APD) and/or the 834.</i> Format/Value: 1-digit alphabetic character (Y or N). ‘Y’ = Yes, ‘N’ = No.	
LTSS Assessment completion date	Date the CCO conducted an assessment of a person identified as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring per 42 CFR 438.208(c)(2).	Enter the date the CCO conducted an assessment. Format/Value: MM/DD/YYYY (e.g., 01/01/2025). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	Yes, when the LTSS Identification question = ‘Y’.
Special Health Care Needs (SHCN) needs identification	Please indicate if the individual has been identified as having SHCN needs as defined by OAR 410-120-0000 (290).	Enter Yes (Y) if the individual has been identified as having SHCN needs or No (N) if not. <i>Note: Use data from the 834 (YSHCN PERC Codes) and/or other sources.</i> Format/Value: 1-digit alphabetic character (Y or N). ‘Y’ = Yes, ‘N’ = No.	Yes, when applicable.
SHCN Assessment completion date	Date the CCO conducted an assessment of a person identified as having SHCN to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring per 42 CFR 438.208(c)(2).	Enter the date the CCO conducted an assessment. Format/Value: MM/DD/YYYY (e.g., 01/01/2025). Null Value: Blank – do not use NA, N/A,	Yes, when SHCN Identification = ‘Y’.

		or other conventions for Null.	
Chronic Disease Diagnosis	Diagnosis code (ICD-10) code(s) that apply to Chronic Disease.	Enter the Diagnosis (ICD-10) code(s) that apply to Chronic Disease. If multiple codes, separate each with a semi-colon. Reminder that ICD-10 codes are alphanumeric and contain 3-7 digits. <i>Note 1: Enter the appropriate diagnosis code corresponding to the four categories mentioned above, using the Care Coordination Report Code Sheet 2025.</i> <i>Note 2: If any member has two or more “Diagnosis Codes” then please add them in same line separated by a semi-colon. Ex: F11.21; F10.21.</i> Format/Value: Alphanumeric characters with special characters associated with Diagnosis codes (e.g., R91.8). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	Yes, when applicable.
Substance Use Disorder (SUD) Diagnosis	Diagnosis code (ICD-10) code(s) that apply to SUD Diagnosis.	Enter the Diagnosis (ICD-10) code(s) that apply to SUD. If	Yes, when applicable.

		multiple codes, separate each with a semi-colon. Reminder that ICD-10 codes are alphanumeric and contain 3-7 digits. <i>Note 1: Enter the appropriate diagnosis code corresponding to the four categories mentioned above, using the Care Coordination Report Code Sheet 2025.</i> <i>Note 2: If any member has two or more “Diagnosis Codes” then please add them in same line separated by a semi-colon. Ex: F11.21; F10.21.</i> Format/Value: Alphanumeric characters with special characters associated with Diagnosis codes (e.g., R91.8). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	
Severe and Persistent Mental Illness (SPMI) Diagnosis	Diagnosis (ICD-10) code(s) that apply to SPMI Diagnosis.	Enter the Diagnosis (ICD-10) code(s) that apply to SPMI. If multiple codes, separate each with a semi-colon. Reminder that ICD-10 codes are alphanumeric and contain 3-7 digits.	Yes, when applicable.

		Note 1: Enter the appropriate diagnosis code corresponding to the four categories mentioned above, using the Care Coordination Report Code Sheet 2025. Note 2: If any member has two or more “Diagnosis Codes” then please add them in same line separated by a semi-colon. Ex: F11.21; F10.21. Format/Value: Alphanumeric characters with special characters associated with Diagnosis codes (e.g., R91.8). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	
Intellectual/Developmental Disability (I/DD) Diagnosis	Diagnosis (ICD-10) code(s) that apply to I/DD Diagnosis.	Enter the Diagnosis (ICD-10) code(s) that apply to I/DD. If multiple codes, separate each with a semi-colon. Reminder that ICD-10 codes are alphanumeric and contain 3-7 digits. Note 1: Enter the appropriate diagnosis code corresponding to the four categories mentioned above, using the Care	Yes, when applicable.

		<i>Coordination Report Code Sheet 2025.</i> Note 2: <i>If any member has two or more “Diagnosis Codes” then please add them in same line separated by a semi-colon. Ex: F11.21; F10.21.</i> Format/Value: Alphanumeric characters with special characters associated with Diagnosis codes (e.g., R91.8). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	
Individuals receiving Child Welfare Services	Please indicate the source of data (Child and Adolescent Report aka CAR or PERC code) and any applicable PERC code(s). Members who are currently receiving services or received services during the reporting period (Q1 or Q2), including: 1. In foster/substitute care; 2. The recipient of adoption or guardianship assistance. Note: <i>CCOs can identify some Members of the child welfare population using the PERC codes</i>	Enter the appropriate category: CAR, 834 or PERC code. Note: <i>If any member has two or more “PERC Codes” then please add them in same line separated by a semi-colon. Ex: 19; C5.</i> Format/Value: 2 to 3-digit numeric character present in 'PERC' Code table in 'PERCID' Column or CAR for Child Welfare Report. Null Value: Blank – do not use NA, N/A,	Yes, when applicable.

	<i>they receive in their daily eligibility files (834), specified in the Care Coordination Report Code Sheet 2025.</i>	or other conventions for Null.	
Individuals receiving Adults and People with Disability (APD) Services	Please indicate if the individual is receiving APD Home and Community Based Services (HCBS). For definition of individual receiving APD HCBS, see OAR 411-049-0102(46).	Enter Yes (Y) if the individual received APD HCBS services during the reporting period or No (N) if not. Note: Use data from APD. Do not use 834 data to report this. Format/Value: 1-digit alphabetic character (Y or N). ‘Y’ = Yes, ‘N’ = No.	Yes, when applicable.
HRCC Changes	Please indicate the category that applies to the HRCC changes noted on the HRCC code table. HRCC Categories: 1. Individuals readmitted to hospital in less than 30 days from discharge for any reason 2. Individuals with ER visit 3. Individuals involved in crisis services, including mobile crisis 4. Individuals recently homeless or at risk for homelessness or	Enter the appropriate category i.e. HRCCID that applies to the categories in the <i>Care Coordination Report Code Sheet 2025</i>. Note: If this occurred multiple times within the reporting period, record each instance on a separate line. Format/Value: 1-digit numeric character / present in ‘HRCC’ code table, ‘HRCCID’ column. Null Value: Blank – do not use NA, N/A, or other conventions.	Yes, when applicable.

	non-placement as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5 5. Two or more caregiver placements in the reporting period (specifically Residential, Long-Term Care or Adult/Child Foster Care) 6. Individuals discharged from carceral settings (Including state, federal prisons, local jail or correctional facilities, tribal correctional facilities and juvenile detention) 7. Individuals discharged from Oregon State Hospital (OSH)		
Date HRCC Changes Occurred	Please indicate the date(s) of each HRCC Change(s).	Enter the date for the HRCC change indicated in the HRCC Changes column. Format/Value: MM/DD/YYYY (e.g., 01/01/2025).	Yes, when HRCC Changes is not blank.

Individuals in a Residential or Long-Term Care Setting	Please indicate if an individual was in a Residential or Long-Term Care Setting during the reporting period. Long-Term Care settings are defined in: OAR 411-054-0005(12) and (56) OAR 411-069-0000(8). Residential settings are defined in: OAR 309-035-0105 (77), (78) and (82) OAR 309-018-0105 (127) and (128) OAR 411-325-0020 (2) OAR 411-054-0005 (90).	Enter Yes (Y) if the individual was in a Residential or Long-Term Care Setting during the reporting period or No (N) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes, when applicable.
Adults in Foster Home Settings (formerly Adult Foster Care)	Please indicate if an individual was in a foster home setting during the reporting period. Adult Foster Home settings are defined in: OAR 411-360-0020 (1) and (2) OAR 411-049-0102 (6) OAR 309-040-0305(6)	Enter Yes (Y) if the individual was in a foster home setting during the reporting period or No (N) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes, when applicable.
Individuals receiving Home Health Services	Please indicate if the individual received home health services during the reporting period. Home health services are defined in OAR 410-120-0000(136).	Enter 'Y' (Yes) if the individual received home health services during the reporting period or 'N' (No) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes, when applicable.

Individuals receiving Hospice Services	Please indicate if the individual received hospice services during the reporting period.	Enter 'Y' (Yes) if the individual received hospice services during the reporting period or 'N' (No) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes, when applicable.
Individuals receiving Palliative Care Services	Please indicate if the individual received palliative care services during the reporting period, as defined in OAR 410-141-3846.	Enter 'Y' (Yes) if the individual received palliative care during the reporting period or 'N' (No) if not. Format/Value: 1-digit alphabetic character (Y or N). 'Y' = Yes, 'N' = No.	Yes, when applicable.
Palliative Care Services ICD-10/CPT Code	Please enter any ICD-10 or CPT codes used to identify individuals receiving palliative care services during the reporting period. This may include ICD-10 Code Z51.5 and CPT Codes 99497 and 99498.	Enter the Diagnosis (ICD-10) or CPT code(s) that apply to I/DD. If multiple codes, separate each with a semi-colon. Reminder that ICD-10 codes are alphanumeric and contain 3-7 digits and CPT Codes are alphanumeric and contain 5 digits. <i>Note: If any member has two or more Diagnosis or CPT Codes then please add them in same line separated by a semi-colon. Ex: F11.21; F10.21.</i> Format/Value: Alphanumeric	Yes, when Individuals receiving Palliative Care Services = 'Y'.

		characters with special characters associated with Diagnosis and/or CPT codes (e.g., Z51.5 and/or 99497). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	
Paper Outreach Attempts	Please indicate the total number of paper care coordination outreach attempts to the member in the reporting period.	Enter the total number of paper outreach attempts to the member. <i>Note: if the member has multiple lines of data due to another data element, enter this number on only one line, leaving the remaining lines blank.</i> Format/Value: numeric character (e.g., 1 or 23). Null Value: Blank – do not use NA, N/A, or other conventions for Null.	Yes, when applicable.
Digital Outreach Attempts	Please indicate the total number of digital care coordination outreach attempts to the member in the reporting period.	Enter the total number of digital outreach attempts to the member. <i>Note: if the member has multiple lines of data due to another data element, enter this number on only one line, leaving the remaining lines blank.</i>	Yes, when applicable.

		Format/Value: numeric character (e.g., 1 or 23) Null Value: Blank – do not use NA, N/A, or other conventions for Null.	
Verbal Outreach Attempts	Please indicate the total number of verbal care coordination outreach attempts to the member in the reporting period.	Enter the total number of verbal outreach attempts to the member. <i>Note: if the member has multiple lines of data due to another data element, enter this number on only one line, leaving the remaining lines blank.</i> Format/Value: numeric character (e.g., 1 or 23) Null Value: Blank – do not use NA, N/A, or other conventions for Null.	Yes, when applicable.

Aggregate Level Care Coordination Log

CCOs must report aggregate statistics reflecting care coordination activities that took place during the reporting time period. Specific items requiring reporting are listed below.

Data Field Name	Data Field Description	Data Field Instructions	Required
New members enrolled	The number of new members enrolled during the reporting time period. “New member” as defined by CCO.	Enter the number of new members enrolled in the CCO during the reporting period. Format/Value: numeric values 0-9 only.	Yes

	This data field should not include duplicates. Ex: If a member exited and enrolled in services more than once in a reporting period, count as “1”.		
New members completed HRAs within 90 days	The number of new members enrolled during the reporting time period who had an HRA completed within the first 90 days.	Enter the number of new members enrolled during the reporting time period who had an HRA completed within the first 90 days. Format/Value: numeric values 0-9 only.	Yes
New member completed HRAs outside 90 days	The number of new members enrolled during the reporting time period who had an HRA completed more than 90 days from enrollment.	Enter the number of new members enrolled during the reporting time period who had an HRA completed more than 90 days from enrollment. Format/Value: numeric values 0-9 only.	Yes
Non-engaged members	The number of members classified as non-engaged as defined by CCO	Report the number of members classified as non-engaged in care coordination activities according to the CCO’s policy. Format/Value: numeric values 0-9 only.	Yes

Narrative Response Requirements:

Please upload a separate document into the portal containing narrative information

1. Please provide an overview of the CCO’s care coordination staffing model. In the response, provide the number and types of clinical and non-clinical staff directly involved in care coordination, include leadership information, including but not limited to Interdisciplinary Team Meetings, readmission, complex care, and Emergency Room case management.
2. Please provide the CCO’s definition of a non-engaged member.

3. What progress has been made to establish information sharing with healthcare partners (APD, CW, etc.) since the initial Risk Stratification demonstration.
4. Please describe any changes to the CCO's approved risk stratification model.
5. Please describe your relationship with Mobile Crisis Services and provide details about receiving data i.e. events that occurred, date, time, any notifications that are set up, whether they are automatic or another process, disposition of mobile crisis response
6. If you entered 'Y' (Yes) for any individuals receiving Palliative Care services, as defined in OAR 410-141-3846, but did not include an ICD-10 or CPT code, please explain how you are identifying and tracking these individuals.
7. Please describe the source(s) of data you used to report on:
 - a. Long Term Service and Supports (LTSS) needs Identification
 - b. Special Health Care Needs (SCHN) Identification
 - c. Individuals in a Residential or Long-Term Care Setting
 - d. Adults in Foster Home or Care Setting
8. Please indicate data sources for each category related to HRCC:
 - a. Individuals readmitted to hospital in less than 30 days from discharge for any reason
 - b. Individuals with ER visit
 - c. Individuals involved in crisis services, including mobile crisis
 - d. Individuals recently homeless or at risk for homelessness or non-placement
 - e. Two or more caregiver placements in the reporting period (specifically Residential, Long-Term Care or Adult/Child Foster Care)
 - f. Individuals discharged from carceral settings (Including state, federal prisons, local jail or correctional facilities, tribal correctional facilities and juvenile detention)
 - g. Individuals discharged from Oregon State Hospital (OSH)
9. Please describe how you ensure outreach is provided in the Member's preferred method of communication and language.