OREGON HEALTH PLAN
Coordinated Care Organizations

Instructions for submitting
Social Needs Service Coordination Report

Updated July 2025

General Information

The Social Needs Service Coordination Report includes information on Health-Related Social Needs (HRSN) program member identification, HRSN program closed loop referrals and care coordination, and social needs providers for CCO programs beyond the HRSN program. Please submit all reports via the CCO Deliverables Portal located at https://oha-cco.powerappsportals.us/. The submitter must have an OHA account to access the portal.

Coordinated Care Organizations (CCOs) must send the following quarterly reports to OHA no later than 45 calendar days from the end of each calendar quarter:

- HRSN Member Identification
- HRSN Closed Loop Referrals and Care Coordination – Manual
- HRSN Closed Loop Referrals and Care Coordination – Community Information Exchange (CIE)

Coordinated Care Organizations must send the following biannual (twice yearly) report to OHA no later than 45 calendar days from the end of both the first and third calendar quarters:

- Social Needs Providers

Please use the Social Needs Service Coordination Report template posted on the CCO Contract Forms page. The tables in this guidance document provide expanded definitions of the data to be entered in the Social Needs Service Coordination Report template.

HRSN Member Identification	Due to OHA: 05/15/25, 08/14/25, 11/14/25, 02/17/26
HRSN Closed Loop Referrals and Care Coordination – Manual	Due to OHA: 05/15/25, 08/14/25, 11/14/25, 02/17/26
HRSN Closed Loop Referrals and Care Coordination – Community Information Exchange (CIE)	Due to OHA: 05/15/25, 08/14/25, 11/14/25, 02/17/26
Social Needs Providers	Due to OHA: 05/15/25, 11/14/25

HRSN Member Identification:

The Member Identification tab collects information about the member's first complete request with a CCO for HRSN services. The data here should represent the potentially eligible population before services are authorized or denied.

The Member Identification tab should include all complete requests for HRSN services (whether from members, caregivers, HRSN providers/Connectors, and/or FFS/Open Card or other CCOs).
A complete request, as defined in OAR 410-120-2010 includes:

A. The name and contact information for the individual recommended;
B. The HRSN Service(s) the individual needs or may need; and
C. A statement that the individual desires to take part in an HRSN Eligibility Screening performed by the MCE, or as applicable, the Authority.

Multiple requests made within the same reporting period (i.e., quarter) may be combined in one row of the report. In these cases, use the Request Date and Request Source from the earliest known request.

Data Field Name	Data Field Description	Date Field Instructions	Required
Member's OHP Medicaid Number	Member's 8-digit alphanumeric Oregon Health Plan ID number	Enter the Member's 8-digit alphanumeric Oregon Health Plan ID number. Do not enter a CCO or Provider ID number. **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X).	Yes
Member's Date of Birth	Date the member was born	Enter the Member's date of birth (DOB). **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes
Request Source	The source of the earliest complete request	Select the appropriate entry from the following options: 1. Request from member/caregiver (self-referral/caregiver referral); 2. Request from HRSN Connector; 3. Request from HRSN Provider; 4. CCO-identified (e.g. care management team, SDOH screening tool, other); 5. Request from Open Card or another CCO; or 6. Other **Format/Value:** Dropdown menu.	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
Request Date	Date the request was received by the CCO	Enter the date the request was received by the CCO. If a member makes multiple or duplicative HRSN requests in the same quarter, log the earliest complete request date. **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes
Home Changes for Health During Extreme Weather Service	Indicate if member is requesting HRSN home changes for health services	Enter a 'Y' if the member is requesting any of the following home changes for health during extreme weather devices: Air conditioners Heaters Air filters Mini fridges for medication or breast milk storage Portable power supplies; or enter 'N' if the member is not requesting home changes for health services. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No. **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
Housing Service	Indicate if member is requesting HRSN housing services other than home changes for health devices	Enter a 'Y' if the member is requesting any of the following housing services: Rent and utility costs Utility arrears Utilities set-up Hotel/motel stays Storage fees Medically necessary home accessibility modifications Medically necessary home remediations Tenancy support services or enter 'N' if the member is not requesting housing services.	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
		Format/Value: 1-digit alphabetic character / 'Y' = Yes, 'N' = No. **Null Value:** Blank – do not use NA, N/A, or other conventions.	
Nutrition Service	Indicate if member is requesting HRSN nutrition services	Enter a 'Y' if the member is requesting any of the following nutrition services; Medically tailored meals Nutrition education Pantry stocking Fruit and vegetable benefit; or enter 'N' if the member is not requesting nutrition services. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No. **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
Outreach & Engagement (O&E) Service	Indicate if member is requesting HRSN outreach & engagement services	Enter a 'Y' if the member is requesting O&E services; or enter 'N' if the member is not requesting O&E services. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No. **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
HRSN Covered Population	HRSN covered population that the member is in	Select the appropriate population from the following options: 1. Adults and youth discharged from an HRSN Eligible Behavioral Health Facility; 2. Adults and youth released from incarceration; 3. Individuals currently or previously involved in Oregon's child welfare system; 4. Individuals transitioning to dual Medicaid and Medicare status;	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
		5. Individuals who are homeless; 6. Individuals who are at risk of homelessness; 7. Young adults with Special Health Care Needs (YSHCN); 8. Unknown; or 9. Not in an HRSN covered population If a member falls into multiple HRSN covered populations, use subsequent columns to indicate additional populations. Preference member self-identification for selecting primary population. **Format/Value:** Dropdown menu.	
Second HRSN Covered Population	HRSN covered population that the member is in	If member belongs to multiple populations (listed above) please list additional population here. **Format/Value:** Dropdown menu.	Optional
Third HRSN Covered Population	HRSN covered population that the member is in	If member belongs to multiple populations (listed above) please list additional population here. **Format/Value:** Dropdown menu.	Optional

HRSN Closed Loop Referrals and Care Coordination – Manual:

The HRSN Manual Referrals tab is to be used when the CCO receives closed-loop referral reports from HRSN providers through any system that is not Community Information Exchange (CIE). If a CCO receives all their closed-loop referral data through CIE, then the HRSN Manual Referrals tab can be left blank.

Each row represents a referral attempt to a single organization for a single service. If a member is receiving multiple services and/or if a single referral covers multiple services, there should be multiple rows with unique service IDs that correspond respectively. A separate line should also be used for every referral attempt for the same service (e.g., first attempt to Organization A is declined and member is subsequently referred to Organization B). Data elements 'Referral Status' and 'Service Status' could change for a

single referral attempt over the course of a quarter; CCOs should report the final status of each referral attempt as of the end of the reporting period.

Data Field Name	Data Field Description	Date Field Instructions	Required
Unique Service-level ID	Unique service identification number	Enter one of the following: 1. Unique service-level internal identification number. Or; 2. Sequential number with "SERV" in front such as: SERV#. (e.g., SERV1, SERV2, SERV3…) Each quarter, the numbering will start over and begin with 1 again. **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s.	Yes
Member's OHP Medicaid Number	Member's 8-digit alphanumeric Oregon Health Plan ID number	Enter the Member's 8-digit alphanumeric Oregon Health Plan ID number. Do not enter a CCO or Provider ID number. **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X).	Yes
Member's Date of Birth	Date the member was born	Enter the Member's date of birth (DOB). **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes
Does the Member Have an HRSN Person Centered Service Plan?	Indicate if member has an HRSN person-centered service plan	Enter a 'Y' if the member has an HRSN person-centered service plan; or enter 'N' if the member does not have an HRSN person-centered service plan. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No.	Yes
Procedure Code	Procedure code, as identified in fee schedule	Enter the procedure code for the specific HRSN service being referred, as identified in the fee schedule. **Format/Value:** 5-digit alphanumeric value (e.g., S5165).	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
		Null Value: Blank – do not use NA, N/A, or other conventions.	
Modifier Code(s)	Modifier code(s) as identified in fee schedule	Enter the modifier code(s), as identified in the fee schedule. If entering multiple codes, separate each with a semi-colon. **Format/Value:** 2-digit alphanumeric value (e.g., V1). **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
Date of the Referral	Date the member was referred to an HRSN provider to receive services	Enter the date at which the member was referred to an HRSN provider to receive services. **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes
Provider Name/ Organization Name to Which Member is Referred	Name of enrolled HRSN provider	Enter the name of the HRSN provider. For multiple referrals provided for the same member for the same service, record each referral on a separate line. **Format/Value:** alphabetic characters, spaces, special characters associated with names.	Yes
DMAP_ID	Individual Service Provider's DMAP (Medicaid ID)	This data field must be populated with the Individual Provider's Group, Clinic, or Organization's ID issued upon enrollment as an Oregon Medicaid provider. **Format/Value:** 6 or 9-digit numeric value.	Yes
Referral Status	Status of referral	Select the appropriate referral status as it stands at the end of the quarter, from the following options: 1. Sent; 2. Recalled; 3. Rejected; or 4. Accepted	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
		Format/Value: Dropdown menu; select one.	
Date of Outreach	Date the HRSN provider first attempted to contact the member after accepting the referral	Enter the date at which the HRSN provider first attempted to contact the member. Leave blank if Referral Status is Sent, Recalled, or Rejected. Leave blank if HRSN provider outreach to member has not yet occurred. **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). **Null Value:** Blank – do not use NA, N/A, or other conventions.	Optional field as of 1/1/25. Required field as of 7/1/2025.
Service Status	Indicate if service has been rendered	Select the appropriate service status from the following options to indicate whether service has been rendered: 1. Yes; 2. No; or 3. Pending **Format/Value:** Dropdown menu; select one.	Yes
Service Status Reason	Reason for status of service	Select the appropriate reason from the following options to further detail service status: 1. Yes - service provided; 2. No – member no longer interested; 3. No – unable to reach member; 4. No - couldn't provide help (for example: deceased, unsafe environment for install, etc.); or 5. Pending – referral in progress **Format/Value:** Dropdown menu; select one.	Yes

HRSN Closed Loop Referrals and Care Coordination - CIE:

The HRSN CIE Referrals tab is to be used for when the CCO receives closed loop referral reports from HRSN providers through Community Information Exchange (CIE). If a CCO receives all their closed loop referral data through other processes, then the HRSN CIE Referrals tab can be left blank. The HRSN CIE Referrals tab is meant to mirror options found in Connect Oregon/Unite Us and Findhelp systems.

Each row represents a referral attempt to a single organization for a single service. If a member is receiving multiple services and/or if a single referral covers multiple services, there should be multiple rows with unique service IDs that correspond respectively. A separate line should also be used for every referral attempt for the same service (e.g., first attempt to Organization A is declined and member is subsequently referred to Organization B). Data elements 'Referral Status' and 'Service Status' could change for a single referral attempt over the course of a quarter; CCOs should report the final status of each referral attempt as of the end of the reporting period.

Data Field Name	Data Field Description	Date Field Instructions	Required
Unique Service-level ID	Unique service identification number	Enter one of the following: 1. Unique service-level internal identification number. Or; 2. Sequential number with "SERV" in front such as: SERV#. (e.g., SERV1, SERV2, SERV3…) Each quarter, the numbering will start over and begin with 1 again. **Format/Value:** alphanumeric characters, spaces, special characters associated with ID #s.	Yes
Member's OHP Medicaid Number	Member's 8-digit alphanumeric Oregon Health Plan ID number	Enter the Member's 8-digit alphanumeric Oregon Health Plan ID number. Do not enter a CCO or Provider ID number. **Format/Value:** 8-digit alphanumeric value (e.g., AZ19936X).	Yes
Member's Date of Birth	Date the Member was born	Enter the Member's date of birth (DOB). **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
Does the Member Have an HRSN Person Centered Service Plan?	Indicate if member has an HRSN person-centered service plan	Enter a 'Y' if the member has an HRSN person-centered service plan; or enter 'N' if the member does not have an HRSN person-centered service plan. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No.	Yes
Procedure Code	Procedure code, as identified in fee schedule	Enter the procedure code for the specific HRSN service being referred, as identified in the fee schedule. **Format/Value:** 5-digit alphanumeric value (e.g., S5165). **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
Modifier Code(s)	Modifier code(s) as identified in fee schedule	Enter the modifier code(s), as identified in the fee schedule. If entering multiple codes, separate each with a semi-colon. **Format/Value:** 2-digit alphanumeric value (e.g., V1). **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes
Date of the Referral	Date the member was referred to an HRSN provider to receive services	Enter the date at which the member was referred to an HRSN provider to receive services. **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023).	Yes
Provider Name/ Organization Name to Which Member is Referred	Name of enrolled HRSN provider	Enter the name of the HRSN provider. For multiple referrals provided to the same member for the same service, record each referral on a separate line. **Format/Value:** alphabetic characters, spaces, special characters associated with names.	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
DMAP ID	Individual Service Provider's DMAP (Medicaid ID)	This data field must be populated with the Individual Provider's Group, Clinic, or Organization's ID issued upon enrollment as an Oregon Medicaid provider. **Format/Value**: 6 or 9-digit numeric value.	Yes
Referral Status	Status of referral	Select the appropriate referral status from the following options: 1. Sent; 2. In Review; 3. Recalled; 4. Auto-Recalled; 5. Rejected; or 6. Accepted Options for Findhelp: 7. Not Updated 8. Needs client action 9. Pending 10. Eligible 11. Referred Elsewhere **Format/Value:** Dropdown menu; select one.	Yes
Date of Outreach	Date the organization first attempted to contact the member	Enter the date at which the organization first attempted to contact the member. Leave blank if Referral Status is Sent, In-Review, Recalled, Auto-Recalled, or Rejected. Leave blank if outreach has not yet occurred. **Format/Value:** MM/DD/YYYY (e.g., 01/01/2023). **Null Value:** Blank – do not use NA, N/A, or other conventions.	Optional field as of 1/1/25. Required field as of 6/1/2025.
Service Status Reason	Reason for status of service	Enter the appropriate detailed reason as it is displayed in CIE. **Format/Value:** Open text field	Yes

Social Needs Providers:

The Social Needs Providers tab is a record of all providers the CCO is contracted with (contract, grant, memorandum of understanding, or other form of agreement) to deliver social needs services across all social needs spending programs. Include any provider that has an open or pending contract during the reporting period. The Social Needs Providers tab includes providers offering services through Health-Related Services (HRS), Supporting Health for All through Reinvestment (SHARE), and other social needs spending programs (exclusive of HRSN). CCOs are still required to report HRSN providers biannually in the Delivery Service Network (DSN), thus CCOs do not need to duplicate reporting of providers who only provide HRSN services in this tab. If providers offer HRSN services in addition to another program, like HRS, they need to be reported.

For the purposes of this report, OHA defines social needs providers to include providers offering services to address health-related social needs as defined in OAR 410-141-3735 (inclusive of but also beyond the Medicaid programs Health-Related Social Needs benefit). For example, a provider who a CCO pays to deliver housing supports to a member that does not qualify under an HRSN Covered Population would be a "social needs provider" for the purposes of this report.

If a provider has multiple site addresses from which services are being delivered to CCO members, please include all addresses.

Data Field Name	Data Field Description	Date Field Instructions	Required
Provider/ Organization Name	Name of provider or organization	Enter the name of the provider or organization. **Format/Value:** alphabetic characters, spaces, special characters associated with names.	Yes
Tax Identification Number (TIN)	Provider Tax identification number	Enter the provider's tax identification number (TIN). **Format/Value:** 9-digit numeric value.	Yes
HRS	Indicate if services provided under HRS flexible services and/or HRS	Enter a 'Y' if provider/organization provides services via HRS flexible services and/or HRS community benefit initiatives; or enter 'N' if	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
	community benefit initiatives funding	provider/organization does not provide HRS services. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No.	
SHARE	Indicate if services provided via SHARE Initiative funding	Enter a 'Y' if provider/organization provides services via SHARE Initiative; or enter 'N' if provider/organization does not provide SHARE Initiative services. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No.	Yes
Other	Indicate if services provided via funding from another program or source other than HRSN (reported elsewhere, HRS, or SHARE)	Enter a 'Y' if provider/organization provides services outside of HRS, SHARE, or HRSN; or enter 'N' if provider/organization does not provide services outside of HRS, SHARE, or HRSN. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'N' = No.	Yes
Address 1	First line of provider's or organization's address	Enter the first line of the provider or organization's site location (physical street address). **Format/Value:** alphanumeric characters, spaces, special characters associated with addresses.	Yes
Address 2	Second line of provider's or organization's address	Enter the second line of the provider or organization's site location (suite number, etc.). Leave blank if none. **Format/Value:** alphanumeric characters, spaces, special characters associated with addresses. **Null Value:** Blank – do not use NA, N/A, or other conventions.	Yes, when applicable
City	Provider's or organization's city	Enter the city where the provider or organization is located.	Yes

Data Field Name	Data Field Description	Date Field Instructions	Required
		Format/Value: alphabetic characters, spaces, special characters associated with city names.	
State	Provider's or organization's state	Enter the state where the provider or organization is located. **Format/Value:** alphabetic characters, spaces, special characters associated with state names.	Yes
Zip	Provider's or organization's zip code	Enter the zip code where the provider or organization is located. **Format/Value:** 5-digit numeric value.	Yes
Phone	Provider's or organization's phone number	Enter the phone number of the provider or organization. **Format/Value:** 10-digit numeric value.	Optional
Website	Provider's or organization's website	Enter the web address/URL for the provider's or organization's website. **Format/Value:** alphabetic characters, spaces, special characters associated with website addresses.	Optional
Contract Status	Indicate if provider or organization has a current formal agreement with CCO	Enter a 'Y' if provider/organization has a current formal agreement with CCO (e.g. contract, grant, memorandum of understanding, data use agreement); or enter 'P' if provider/organization has a pending formal agreement with CCO. **Format/Value:** 1-digit alphabetic character / 'Y' = Yes, 'P = Pending.	Optional field as of 1/1/25. Required field as of 1/1/2026.