



# Supporting Health for All through REinvestment: the SHARE Initiative

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This document will provide guidance to help coordinated care organizations (CCOs):

- 1) Meet the SHARE Initiative requirements; and
- 2) Report accurately on their SHARE Initiative spending to the Oregon Health Authority (OHA).

## Background and overview

The Oregon Health Authority (OHA) developed the SHARE Initiative to implement the legislative requirements in Enrolled Oregon House Bill 4018 (2018) to address social determinants of health and health equity. SHARE Initiative spending is legislatively required, is in CCO contract, applies to those CCOs that exceed financial requirements<sup>1</sup> and is spent from excess end-of-year profits. The SHARE Initiative began in 2020.

The primary goals of the SHARE Initiative are to:

- Safeguard public dollars by requiring that a portion of CCOs’ profits<sup>1</sup> are reinvested in their communities; and
- Improve CCO member and community health by requiring reinvestments go toward upstream non-health care factors that impact health (for example, housing, food, transportation, educational attainment or civic engagement).

<sup>1</sup> House Bill 4018 refers to “annual net income or reserves of the CCO that exceed the financial requirements specified in this paragraph....” This document uses the term “profits” as a shorthand equivalent to encompass the statutory terms.

The SHARE Initiative includes the following program requirements:

[Requirement 1](#): Spending must fall within social determinants of health and equity (SDOH-E) domains and include spending toward a statewide housing priority.

[Requirement 2](#): Spending priorities must align with community priorities from community health improvement plans (CHPs).

[Requirement 3](#): A portion of funds must go to SDOH-E partners.

[Requirement 4](#): CCOs must designate a role for their community advisory councils (CACs) related to SHARE Initiative spending decisions.

These program requirements are informed by the Oregon Medicaid Advisory Committee (MAC) definition of and recommendations on social determinants of health as well as the Oregon Health Policy Board's [CCO 2.0 policy recommendations](#). Additional guidance and definitions can be found in the [2024 CCO contract](#), [OAR 410-141-3735](#) and on [OHA's SHARE Initiative webpage](#).<sup>i</sup>

It is important to note that the SHARE Initiative is just one way CCOs may respond to SDOH-E, health inequities, and the social needs of their members and communities. OHA encourages CCOs to create a community investment strategy that meets their local community needs and braids multiple investment mechanisms/pathways including the SHARE Initiative obligation.

## SHARE requirement 1: SDOH-E domains and housing priority

Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- SHARE Initiative spending must meet OHA's definition of SDOH-E and fall into one or more of four domains: economic stability, neighborhood and built environment, education, and social and community health; and
- A portion of a CCO's SHARE Initiative spending must be spent on housing-related services and supports.

### Definition of SDOH-E

In 2019, OHA adopted a definition of social determinants of health and health equity (SDOH-E),<sup>ii</sup> which is available in OAR 410-141-3735. The SDOH-E definition encompasses three interrelated terms as defined below.

- ✓ **Social determinants of health (SDOH)**: The social, economic and environmental conditions in which people are born, grow, work, live and age, which are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.
- ✓ **Social determinants of equity (SDOE)**: Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels; institutional bias; discrimination; racism and other factors.
- ✓ **Health-related social needs (HRSN)**: An individual's social and economic barriers to health, such as housing instability or food insecurity.

See Appendix A for more SHARE-related definitions.

## Four SDOH-E domains for SHARE Initiative spending and examples

In addition to meeting the general definitions above, SHARE Initiative spending must target at least one of four domains of SDOH-E as prioritized by the MAC:<sup>iii</sup>

1. Economic stability
2. Neighborhood and built environment
3. Education
4. Social and community health

See Appendix B for a list of project ideas and prior CCO examples within each of the four domains, including examples of using braided funding. The list is not comprehensive.

See more project examples that meet the housing priority in the next section.

### Statewide priority: Housing-related services and supports

Due to a statewide housing crisis and feedback during the CCO 2.0 policy engagement period, the Oregon Health Policy Board identified housing-related services and supports as a statewide priority of SHARE Initiative spending. “Housing-related services and supports” means the **services and supports that help people find and maintain stable and safe housing**.

Within the area of housing-related services and supports, OHA has prioritized both project-based *supportive* and tenant-based *supported* housing. OHA is also supporting a statewide effort to increase permanent supportive housing (see definition on next page). CCOs are encouraged to explore ways to use SDOH-E spending for these initiatives, in collaboration with their community and CAC, to invest in the most effective and robust interventions possible. CCOs are also encouraged to include physical accessibility in housing investments.

SHARE dollars come from a CCO’s net profits or reserves and are not considered in the medical loss ratio or rate development. Because of this, SHARE projects have the flexibility to fund room and board as long as it’s not a covered benefit (see next paragraph) for the population being served.

SHARE dollars may **not** be spent on the housing-related supports that are covered benefits for OHP members who qualify as [at risk of homelessness](#) under Oregon’s [1115 Medicaid waiver](#) (beginning in November 2024) or [Substance Use Disorder 1115 waiver](#). See [SHARE Initiative investments and Oregon’s 1115 Medicaid Waiver section](#) of this guidance document for more details.

Examples of projects addressing the housing requirement are in Appendix B.

**Note: Strategies targeted exclusively at health care or access to health care are not included in these SDOH-E domains for eligible SHARE spending, as these are part of a CCO’s foundational work in Oregon’s health care system. Dollars from the SHARE Initiative are meant to address needs beyond the “clinic walls” through community partnerships.**

**Supported housing:** Supported housing is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and available but are not mandated as a condition of obtaining tenancy. See Appendix A for full definition.

**Permanent supportive housing:** Permanent supportive housing combines lease-based, affordable housing with tenancy supports and other voluntary services to more effectively serve the most vulnerable populations. This includes people who are houseless or at risk of becoming houseless and people who are institutionalized or at risk of institutionalization. Permanent supportive housing generally refers to a specific building or site dedicated to providing deeply affordable housing paired with housing supports.

## SHARE requirement 2: Community health improvement plan alignment

SHARE Initiative spending is intended to support community-driven initiatives to improve health. Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- SHARE spending priorities must be based on shared priorities from the community health improvement plans (CHPs) in a CCO's service area.

CCOs have been required to develop CHPs since 2012. More recently, the CCO contract and OAR [410-141-3730](#) require CHPs to be shared with local public health authorities, hospitals, other CCOs and any of the nine federally recognized Tribes of Oregon in the CCO's service area. OHA developed [CCO Guidance: Community Health Assessments and Community Health Improvement Plans](#) to help CCOs meet this requirement.

If a CCO doesn't have a fully shared CHP, the CCO must identify spending priorities by looking at how their CCO's CHP priorities align with the CHPs of community partners (including local public health, hospitals, Tribes and CCOs in the area). Based on this process, CCO priorities might be fully aligned with other CHPs. For example, a CCO could identify supportive housing, which is a priority in all CHPs in its service area. However, alignment could also be based on:

- **A common health outcome:** For example, a community priority is obesity and the CCO's SHARE spending priority is food insecurity to address obesity; or
- **A common priority population:** For example, the community priority is children, and the CCO's SHARE spending priority is stable housing for children and families.

SHARE spending should align with the CCO's most recent CHP at the time of SHARE spending plan submission.

## SHARE requirement 3: SDOH-E partners

CCOs' SHARE Initiative efforts should leverage cross-sector partnerships with organizations that are already trusted in their communities to provide social services and work for policy and systems change. OHA refers to these types of organizations as SDOH-E partners. Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- A portion of SHARE dollars must go directly to SDOH-E partners.

As described in OAR 410-141-3735, an SDOH-E partner is:

- A) A single organization, local government, one or more of the Nine Federally Recognized Tribes of Oregon, the Urban Indian Health Program, or a collaborative that
- B) Delivers SDOH-E related services or programs, or supports policy and systems change, or both, within a CCO's service area.

The definition of SDOH-E partner is broad to include many types of organizations. It includes partners that primarily address individual social needs (for example, social service agencies), as well as organizations that work for policy and systems change to address SDOH-E (for example, regional health equity coalitions), and those that do both (for example, community-based organizations and local health departments). Here are some examples of potential SDOH-E partners:

- Nonprofit social and human service organizations (for example, organizations supporting economic opportunity; supporting individuals with disabilities; or promoting safe housing, education, food security and environmental justice)
- Culturally specific organizations
- Local public health authorities
- Regional health equity coalitions
- Local government and government-associated entities
- Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program
- Educational services districts and school districts
- Early learning hubs
- Local housing authorities

Note: While ideally CCOs also have strong partnerships with clinics and other health care provider partners to support SDOH-E efforts, **SDOH-E partners are intended to be non-clinical partners**. However, organizations that offer both clinical and non-clinical services (such as a housing organization with a clinic or a local public health authority) are also appropriate partners in this context. CCOs will need to clearly describe how the project and specific activities, items or services being funded support SDOH-E.

The CCO must enter into a written agreement (for example, contract, memorandum of understanding or grant agreement) with each SDOH-E partner that defines minimum requirements listed below. Starting in 2024, **CCOs don't need to submit the partner agreements to OHA** as part of the spending plan.

If the written agreement is a subcontract as defined in the CCO contract, then it must also satisfy all requirements in [Exhibit B, Part 4, Section 11 of the CCO contract](#). The CCO must include any subcontracts with SDOH-E partners in its next Subcontractor and Delegated Work Report submission to OHA.<sup>2</sup>

**The CCO shall have a written agreement with each SDOH-E partner** that meets the following minimum requirements prior to disbursing funds:

- Legal names for all entities;
- Contract term, budget and distribution plan/schedule;
- The scope of work to be performed, including:
  - Goals and objectives

<sup>2</sup> The 2024 CCO contract states CCOs must submit an updated Subcontractor and Delegated Work Report with the SHARE spending plan submission. This is no longer needed because SHARE reviewers can access the reports through the CCO deliverables portal. OHA will update the 2025 CCO contract to align with this guidance document.

- Consider using specific, measurable, achievable, relevant, time-based, inclusive and equitable (SMARTIE) objectives (see SMARTIE resources)
  - Specific items, activities or services to be funded
  - Which populations will be affected (for example, CCO members, community members, Tribal communities, communities of color, etc.);
- Plan for collecting and sharing data and reporting obligations of both the SDOH-E partner and the CCO, as applicable to each funded project. This may include:
  - The data elements to be collected by the SDOH-E partner and/or the CCO;
  - How data is related to outcomes; and
  - Process and frequency of submission of reports and/or data exchange between SDOH-E partner and CCO.

The CCO may also choose to include the following:

- Contingency statement about SHARE funds not being used to fund Medicaid covered services, including health-related social needs covered services;
- Plan for measuring and evaluating outcomes; and
- Any other details specific to the funded work.

## SHARE requirement 4: Community advisory council role

Each CCO has at least one community advisory council (CAC), which includes CCO consumer members and other community members who advise the CCO on how to improve health quality and services in their community. Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- The CCO is responsible for providing a role for its CAC in SHARE Initiative spending decisions.

Below are some examples of what this role could look like, but this list is not comprehensive:

- The CAC identifies and/or approves SDOH-E priorities for SHARE that align with community priorities in the CHP.
- The CAC develops a rubric to score SHARE Initiative proposals.
- The CAC (or a subset of its CAC members) reviews SHARE Initiative proposals and makes recommendations to the CCO leadership or board.
- The CCO designates a portion of funding for the CAC to direct to SHARE Initiative efforts.
- The CAC designs the SHARE spending process, including plans for ongoing monitoring and evaluation.

For CAC resources, visit the [CAC supports webpage](#).

## SHARE minimum spending formula and obligation

CCOs are subject to a formula that determines their required minimum SHARE obligation based on their prior calendar year financial reporting. CCOs will follow the instructions in the Exhibit L, Report L6.7 financial reporting template to apply this formula to their prior year financials and report their current year SHARE minimum obligation (cell G38) and designation (cell G40). CCOs will describe how their designation will be spent in their spending plan. This requirement is reflected in OAR 410-141-3735.



If a CCO does not exceed minimum financial reserve requirements<sup>iv</sup>, they are presumed exempt from the SHARE Initiative. CCOs have three years to spend down each year's SHARE designation. CCOs have the option to request a one-year extension (four years total).

The SHARE obligation shall equal or exceed the greater of:

- **A percentage of average adjusted net income** for the prior three calendar years on a sliding scale based on the CCO's risk-based capital (RBC) percentage at the end of the prior calendar year (but prior to the SHARE portion calculation):
  - 0% of adjusted net income at or below 300% RBC, grading up to 20% of adjusted net income at or above 500% RBC; or
- **10% of dividends** recorded or similar payments or both to shareholders, **including adjusted net income earned by capitated affiliates**
  - Capitated affiliates' adjusted net income is calculated with respect to the capitated affiliates' lines of business under the CCO as reported to OHA through the CCO's financial statements under OAR [410-141-5015](#).
  - Dividends or similar payments solely designated to satisfy tax obligations of affiliates that arise on account of serving the CCO's Oregon Health Plan members shall be excluded, provided that the CCO provides documentation approved by OHA.

The formula and specifications are reflected in the Exhibit L template published to OHA's [CCO Contract Forms page](#). See OAR 410-141-3735 for additional details on application of the formula and its defined terms.

## Changes to SHARE designations and plans

A CCO may not reduce their SHARE designation below their required minimum obligation (based on the formula described above). CCOs are also expected to honor their financial commitment (designation) to community partners through SHARE and consider the impact of a funding change before doing so.

If a CCO needs to change their total SHARE designation amount (and it is still above the required minimum amount); the partners they're funding; or major activities, they must notify OHA of the change for review and approval by submitting the following:

- An **amended SHARE spending plan** reflecting the changes submitted through the [CCO Deliverables Portal](#).
  - The amended plan must describe the change, rationale for the change and the community impact of the requested change, including specific partners affected by the change.
- **Exhibit L** should only reflect SHARE designation changes that have been previously submitted and approved by OHA and received no later than the original due date of the CCO-audited financial reports (June 30).

If a CCO changes their SHARE designation amount, OHA is obligated to publicly post the changed SHARE designation to maintain transparency. All SHARE reporting, including designation changes, will be posted to the [SHARE Initiative reports webpage](#).

# SHARE Initiative investments and Oregon's 1115 Medicaid waiver

SHARE investments may not be used to pay for any Medicaid covered services or benefits, including the new health-related social needs (HRSN) covered services. However, there are opportunities to braid funding to more fully support communities. See examples of braided funding in Appendix B.

## Health-related social needs benefit

The 1115 Medicaid waiver presents an additional opportunity for CCOs to address equity and the social determinants of health or social needs of their members. As part of the 1115 Medicaid waiver, covered services for the HRSN benefit will include climate-related supports, housing supports, nutrition supports and related administrative costs as outlined in future amendments to the 2024 CCO contract and in the 2025 CCO contract. The covered services will be implemented over the waiver demonstration period (2022–2027) for eligible populations. Please refer to the CCO contract documents and [2022–2027 Medicaid 1115 Demonstration Waiver webpage](#) for updates on HRSN benefit guidance, details on implementation timelines, eligible populations and covered services.

Since SHARE investments cannot support any covered services or benefits, including HRSN covered services, OHA advises CCOs to consider the following for 2024 SHARE spending plans:

- Use SHARE investments to support populations who are not part of the life transition populations defined in the Oregon 1115 waiver HRSN covered services.
- Invest in SDOH-E efforts that do not overlap with specific HRSN covered services.
- Invest in and disburse SHARE funding for housing- and food-related supports prior to those respective HRSN covered service implementation start dates.
- Braid SHARE funding and HRSN covered services to support the specific activities eligible through each funding stream to meet community needs.

## Community capacity-building funds (CCBF)

As part of the 1115 Medicaid waiver, Oregon has been approved to spend up to \$119 million in community capacity-building funds (CCBF), specifically to support investments to enable partners that will become HRSN providers to develop what they need to be able to participate in the Medicaid delivery system and deliver HRSN services to qualified OHP members. CCOs will administer the majority of CCBF, via grants, except for those funds reserved for Tribal Governments. CCOs will be responsible for activities including conducting outreach to entities regarding the funding opportunity, receiving and reviewing applications and awarding funding to eligible entities. Some of the activities these capacity-building funds can support<sup>3</sup> are similar to what SHARE Initiative funding can support, including:

- Technology
- Development of business or operational practices
- Workforce development

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<sup>3</sup> CCBF are authorized by the Centers for Medicare and Medicaid Services (CMS) and restricted to CMS-authorized uses. CMS refers to CCBF as “designated state health programs (DSHP) infrastructure funds.”



- Outreach, education and convening

OHA encourages CCOs to utilize all available federal CCBF before funding similar activities through SHARE. OHA also encourages CCOs to braid different funding streams like community capacity-building funding and SHARE to meet community needs.

Learn more about CCBF on the [community capacity-building funds webpage](#).

## Spending exclusions for the SHARE Initiative

In general, SHARE dollars may be spent in a variety of ways as long as they comply with the overall requirements in this guidance document, in rule and in the CCO contract. Because these dollars are part of a CCO's annual net profits, they are not held to the same restrictions as the CCO's Medicaid global budget.

However, SHARE dollars **may not** be spent on:

- Medicaid-covered services<sup>4</sup> (a CCO may not count expenses that are factored into its global budget);
- Any covered services or benefits in Oregon's [Substance Use Disorder \(SUD\) waiver](#) (housing or employment supports for eligible members);
- Any covered services or benefits in [Oregon's 1115 Medicaid waiver](#), including health-related social needs (HRSN) covered services for eligible members (beginning in 2024);
- Any activities, projects or initiatives targeted exclusively at delivery of health care or expanding access to care;
- Expenses that have been reported separately, such as health-related services (HRS) or in lieu of services (ILOS) — CCOs may not double-count spending;
- General administrative costs that are not directly related to a SDOH-E and/or health disparities initiative;
- General administrative costs that are otherwise necessary for the regular business operations of the CCO and compliance with federal/state requirements (for example, providing interpreters), including any staffing required by contract (for example, traditional health worker liaison);
- Sponsorships or advertising;
- Equipment or services to address an identified medical need (for example, corrective lenses, specialized clothing);
- Member incentives (for example, gift cards or cash) for accessing covered services or other non-SDOH-E activities;
- Costs for SDOH-E related research in which findings are only used internally, only used by another private entity or are proprietary;
- Educational or promotional items or goods for general distribution through a health fair or other event not targeted at populations experiencing health disparities;
- Political campaign contributions; or

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<sup>4</sup> Medicaid-covered services do not qualify as SHARE Initiative spending, as they are already reported through existing financial reporting mechanisms. While certain Medicaid-covered services address an individual's social needs (for example, some behavioral health populations may be eligible for certain housing-supportive services through Medicaid), these services are not eligible for SHARE spending.

- Advocacy specific to CCO operations and financing (as opposed to advocacy for policy that advances SDOH-E objectives).

See Appendix C for a checklist to help determine whether a project is eligible for SHARE spending. CCOs are encouraged to contact OHA at [Transformation.Center@odhsoha.oregon.gov](mailto:Transformation.Center@odhsoha.oregon.gov) with questions about allowed and disallowed uses of SHARE dollars prior to developing their spending plans.

## SHARE Initiative reporting

CCOs are required to submit annual financial and narrative reports related to the SHARE Initiative. Reports, details and deadlines are listed in the table below and Appendix D: SHARE Timeline. The Exhibit L reporting templates identified below are provided on the [CCO Contract Forms webpage](#). The SHARE Initiative templates are provided on the [SHARE Initiative webpage](#). CCOs are required to use the OHA-provided spending plan template.

| CCO deliverable   | Description   | Next due  |
|---|---|---|
| <b>SHARE Initiative Spend-Down Report</b><br><a href="#">Exhibit L, Report 6.71</a> | Annual report of year-over-year spend-down of total SHARE funds and detailed spending per partner.  | <b>June 30;</b><br>reporting on<br>2023 spending                                |
| <b>SHARE Initiative Detailed Spending Report</b>                                    | Beginning in 2024, this report is no longer required — it will be consolidated with the SHARE Initiative Spend-Down Report in Exhibit L, Report L6.71, with a secondary table to report detailed spending per partner per year.   | <b>n/a</b>  |
| <b>2024 SHARE Initiative Designation</b><br><a href="#">Exhibit L, Report 6.7</a>   | Annual report for CCO to identify its SHARE Initiative designation based on the prior year’s financials (the portion of net income/reserves the CCO will contribute to the SHARE Initiative). This report also includes other related values, including: 1) annual risk-based capital prior to SHARE contribution; 2) annual pre-tax net income prior to SHARE contribution; and 3) dividends recorded. | <b>June 30;</b><br>based on 2023<br>financials                                  |
| <b>2024 SHARE Initiative Spending Plan</b><br><a href="#">(Required template)</a>   | Annual plan includes SDOH-E priorities, partner information, proposed budgets and other information as required by contract, using the template provided.   | <b>December 31<sup>5</sup>,</b><br>for CCOs with a<br>2024 SHARE<br>designation |

<sup>5</sup> CCOs may submit their spending plans at any time from 4/1 through 12/31. OHA will notify each CCO about the approval status of its plan within 30 days of receipt. If a CCO’s plan cannot be approved as submitted, OHA will work with the CCO to resolve the identified deficiencies as quickly as possible.

# References

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<sup>i</sup> OHA HRS website: [www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx](http://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx)

<sup>ii</sup> Oregon Medicaid Advisory Committee. (May 2018). Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon’s CCO Model. Available at: [www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC\\_AddressingSDOH\\_CCOmodel\\_Recommendations\\_FINAL.pdf](http://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf)

<sup>iii</sup> Oregon Medicaid Advisory Committee. (May 2018). Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon’s CCO Model. Available at: [https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC\\_AddressingSDOH\\_CCOmodel\\_Recommendations\\_FINAL.pdf](https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf)

<sup>iv</sup> 2019 legislation that modified minimum financial standards for CCOs, over which a portion must be dedicated to the SHARE Initiative available in Senate Bill 1041, Section 57, 1(b) <https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB1041/Enrolled>

## Appendix A: Definitions

**Health equity:** When all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Source: [CCO contract, Exhibit A](#)

**Health-related social needs (HRSN):** An individual's social and economic barriers to health, such as housing instability or food insecurity.

Source: [OAR 410-141-3735](#)

**Permanent supportive housing:** Permanent supportive housing combines lease-based, affordable housing with tenancy supports and other voluntary services to more effectively serve the most vulnerable populations. This includes people who are houseless or at risk of becoming houseless and people who are institutionalized or at risk of institutionalization. Permanent supportive housing generally refers to a specific building or site dedicated to providing deeply affordable housing paired with housing supports.

Source: [Oregon's Statewide Housing Plan \(2019-2023\)](#)

**SDOH-E partner:** A single organization, local government, one or more Nine Federally Recognized Tribes of Oregon, the Urban Indian Health Program, or a collaborative, that delivers social determinants of health and health equity (SDOH-E) related services or programs, or supports policy and systems change, or both, within a CCO's service area.

Source: [OAR 410-141-3735](#)

**SHARE designation:** The amount of funding a CCO chooses and reports as a contribution for SHARE initiative spending; designation amount must be at least the minimum SHARE obligation.

**SHARE designation year:** The year in which the CCO reports the SHARE designation amount to OHA (based on previous year's financials).

**SHARE obligation:** The amount of funding a CCO is required to contribute to the SHARE Initiative based on audited financials and the statutory required formula. The formula and specifications are reflected in the Exhibit L, Report L6.7 template published to OHA's [CCO Contract Forms page](#). See [OAR 410-141-3735](#) for additional details on application of the formula and its defined terms.

**SHARE Initiative:** The requirement, created through HB 4018, that CCOs invest a portion of profits back into communities to address health inequities and the social determinants of health and equity.

**Social determinants of health (SDOH):** The social, economic and environmental conditions in which people are born, grow, work, live and age, which are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.

Source: [OAR 410-141-3735](#)

**Social determinants of equity (SDOE):** Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels; institutional bias; discrimination; racism and other factors.

Source: [OAR 410-141-3735](#)

**Supported housing:** Supported housing is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported housing is scattered site housing. To be considered supported housing, for buildings with two or three units, no more than one unit may be used to provide supported housing for people with serious and persistent mental illness (SPMI) who are referred by OHA or its contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for people with SPMI who are referred by OHA or its contractors. Supported housing has no more than two people in a given apartment or house, with a private bedroom for each person. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported housing providers cannot reject individuals for placement due to history of medical or substance use disorder needs.

Source: [CCO contract, Exhibit A](#)

## Appendix B: SHARE project examples

### Project ideas and prior CCO examples by social determinants of health and equity (SDOH-E) domains

| SDOH-E domain                      | Project ideas  | Examples of prior SHARE projects   |
|------------------------------------|--|--|
| Economic stability                 | <ul style="list-style-type: none"> <li>• Income/poverty</li> <li>• Employment</li> <li>• Food security/insecurity</li> <li>• Diaper security/insecurity</li> <li>• Access to quality childcare</li> <li>• Housing stability/instability (including houselessness)</li> <li>• Access to banking/credit</li> </ul>                                     | <ul style="list-style-type: none"> <li>• Train childcare teachers of children of domestic violence survivors</li> <li>• Purchase mobile shower and laundry facility</li> <li>• Purchase a multi-unit residence to create transitional housing</li> <li>• Develop an independent living curriculum for residents at a youth transitional housing facility</li> <li>• Fund local food system resiliency efforts, including strategic planning, Farm to School implementation, nutrition education and supports for culturally specific food organizations</li> <li>• Renovate a multi-service center for providing housing supports and services</li> </ul>  |
| Neighborhood and built environment | <ul style="list-style-type: none"> <li>• Access to healthy foods</li> <li>• Access to transportation (non-medical)</li> <li>• Quality, availability, and affordability of housing</li> <li>• Crime and violence prevention (including intimate partner violence)</li> <li>• Environmental conditions</li> <li>• Access to outdoors, parks</li> </ul> | <ul style="list-style-type: none"> <li>• Provide nutritious meals for homebound seniors and in congregate settings</li> <li>• Implement Veggie Rx programs</li> <li>• Purchase age-inclusive accessible playground equipment</li> <li>• Implement oral health campaign to promote increased fruit/vegetable or decreased sugar-sweetened beverage consumption</li> <li>• Build a commercial kitchen to provide shelf stable, nutritious meals for community members</li> <li>• Fund site and architecture planning for a community of small, affordable cottages</li> <li>• Remodel a former hotel into transitional housing with wrap-around services for community members transitioning out of substance use disorder recovery facilities</li> <li>• Build an ADA-accessible wheelchair ramp to a community storefront that provides free clothes, furniture and household items</li> <li>• Renovate and provide critical repairs to restore operations of a local fire department</li> <li>• Purchase and install signage in community parks that provide exercise prompts, tips on navigating unfamiliar areas and a map of accessibility features to encourage physical activity through the winter</li> </ul> |



|                             |   |   |
|-----------------------------|---|---|
| Education                   | <ul style="list-style-type: none"> <li>• Early childhood education and development</li> <li>• Language and literacy</li> <li>• High school graduation</li> <li>• Enrollment in higher education</li> </ul>  | <ul style="list-style-type: none"> <li>• Provide intergenerational youth enrichment activities</li> <li>• Plan and construct a new schoolyard</li> <li>• Provide high school completion programs, such as mentoring programs</li> <li>• Support school districts to fund skills trainers and behavioral interventionists</li> <li>• Launch a kindergarten readiness program for communities of color</li> <li>• Expand parenting education and child development program to support American Indian Alaska Native families</li> <li>• Provide parenting education, support groups, camps and at-home therapy equipment for children with disabilities and their families</li> <li>• Renovate classrooms, including ADA-accessible restrooms, at an early education center</li> <li>• Purchase equipment and educational and vocational materials for a technology room within a women and children’s transitional housing facility</li> </ul> |
| Social and community health | <ul style="list-style-type: none"> <li>• Social integration</li> <li>• Civic participation and community engagement</li> <li>• Meaningful social role</li> <li>• Discrimination (for example, race, ethnicity, culture, gender, sexual orientation, disability)</li> <li>• Citizenship/immigration status</li> <li>• Corrections/carceral support</li> <li>• Trauma (for example, adverse childhood experiences)</li> </ul>   | <ul style="list-style-type: none"> <li>• Fund staff time and training for traditional health worker and peer wellness support for social service navigation</li> <li>• Fund community-based organizations for start-up, staffing and training for a social needs screening and referral system through a community information exchange</li> <li>• Support interagency strategic planning to assist unhoused and housing insecure individuals to access resources through community information exchange</li> <li>• Build capacity and develop workforce to provide social-emotional health resources for families and children</li> <li>• Fund capital expenses for a community health worker community center</li> </ul>  |
| All domains                 | <ul style="list-style-type: none"> <li>• Fund a medical legal partnership to support members with legal concerns related to housing, discrimination, immigration, and other areas</li> <li>• Fund community-based organization licenses and/or infrastructure to use community information exchange (CIE) platform</li> <li>• Aggregate and evaluate local health and community services data to inform local decision-makers and improve population health and equity</li> </ul> |   |

## Braided funding project examples

| Project examples            |  |
|-----------------------------|--|
| Examples of braided funding | <ul style="list-style-type: none"> <li>• With SHARE funds, remodel and develop a hotel into combination transitional housing and service location for providing wraparound services for community members with substance use disorder transitioning from recovery facilities. Using health-related services (HRS) flex dollars, some units are earmarked for CCO members.</li> <li>• With SHARE funds, build capacity of the local healthy homes program to increase bi-directional referrals through a CIE. When social needs for participants are identified, HRS flexible funding is used to address qualifying member needs.</li> <li>• With SHARE funds, support the local community action agency’s rapid rehousing program by purchasing housing units reserved for CCO members. Through HRS and HRSN, provide short-term rental assistance for CCO members housed in the units.</li> </ul> |

## Housing project examples

| Housing priority   | Individual-level project examples   | Community-level project examples   |
|--|---|--|
| <p>Housing-related supports and services</p> <p>Note: Projects to meet the housing-related supports and services requirement must also fall into one or more of the four SDOH-E domains above.</p> | <ul style="list-style-type: none"> <li>• Provide healthy homes assessments, repairs and enhancements for members with respiratory illness and/or balance/mobility challenges to improve overall health and prevent potential falls, injuries or worsening of health conditions</li> <li>• Provide navigation services, move-in and rental assistance for community members living with HIV and experiencing homelessness</li> <li>• Fund daytime drop-in service center that provides first and next step housing conversations, emergency housing vouchers and help with rental and housing applications</li> <li>• Provide homeownership trainings and support services for families with children</li> </ul> | <ul style="list-style-type: none"> <li>• Partner with local housing organizations and/or community-based organizations to combat discrimination in housing communities</li> <li>• Create a permanent, affordable housing community for low income and unsheltered residents</li> <li>• Create, convene and fund a regional housing coalition</li> <li>• Construct ADA-accessible temporary housing units, including on-site showers, kitchen and laundry units</li> <li>• Construct permanent supportive housing for individuals experiencing or with a history of substance use or mental illness</li> <li>• Renovate a substance use treatment facility with on-site peer support social needs services</li> <li>• Build capacity for a local housing authority to continue construction and repair of homes</li> <li>• Contribute to capital costs for permanent affording housing through land trusts and limited equity cooperatives</li> </ul> |

# Appendix C: SHARE Initiative project eligibility checklist

To be eligible for SHARE spending, projects or activities must meet the following criteria. More details are available in the [SHARE Initiative guidance document](#). If you have additional questions, please email [Transformation.Center@odhsoha.oregon.gov](mailto:Transformation.Center@odhsoha.oregon.gov)

The project **WILL**:

- Address at least one domain of **social determinants of health and equity (SDOH-E)**: economic stability, neighborhood and built environment, education or social and community health. See the [guidance document](#) for examples of each of the domains.
- Fund **non-clinical, upstream activities** — that is, it is not focused on health care or accessing health care (which are part of a CCO's foundational work in Oregon's health care system).
- Align with the CCO's community health improvement plan** priorities.
- Address the statewide priority of housing-related supports and services**. If it does not address housing-related supports and services, the CCO's SHARE spending plan must include at least one other project that does.
- Include a **role for the CCO's community advisory council** in selecting or approving the project.
- Fund an SDOH-E partner**. If the dollars aren't going to an SDOH-E partner, the CCO's SHARE spending plan includes other projects with funds going to one or more SDOH-E partners.

The project will **NOT fund**:

- Medicaid/Oregon Health Plan (OHP)-covered benefits** or the delivery of Medicaid/OHP-covered benefits. This includes the expanded covered benefits in Oregon's [Substance Use Disorder \(SUD\) waiver](#) (housing or employment supports for eligible members) or [1115 Medicaid waiver](#) (health-related social needs services for eligible members, beginning in 2024).
- Equipment or services to address an identified medical need**
- Activities also submitted as health-related services (HRS)** or otherwise double-counted as other expenses
- General administrative costs** that are otherwise necessary for the regular business operations of the CCO
- Member incentives** (for example, gift cards or cash) for accessing covered services or other non-SDOH-E activities
- Educational or promotional items or goods for general distribution** through a health fair or other event not targeted at populations experiencing health disparities
- Political campaign contributions**
- Advocacy specific to CCO operations and financing**
- SDOH-E related research** in which findings are only used internal to CCO, only used by another private entity or are proprietary. If research is funded through SHARE, findings must have broader community impact.

# Appendix D: Timeline of SHARE Initiative planning, reporting and spending

