Flexible Services Guide for CCOs: Frequently Asked Questions (FAQ)

Updated December 2025

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Background

Flexible services began in 2013 with the inception of Oregon's coordinated care organizations (CCOs). The history of flexible services and how it has evolved is further detailed in the Flexible Services Brief. One of the purposes of flexible services is to give CCOs a specific way to use their global budgets to address the social determinants of health (SDOH), including the non-covered health-related social needs of their members.

For CCOs to use federal Medicaid funds for flexible services, they must comply with state and federal criteria. Flexible services requirements are detailed in Oregon Administrative Rule (OAR) and Code of Federal Regulations (CFR). For a full definition of flexible services, CCOs should rely primarily on the Oregon Health Authority (OHA) Flexible Services Brief and OARs 410-141-3500 and 410-141-3845. The federal regulations (45 CFR 158.150 and 45 CFR 158.151) should be used for supplemental CCO guidance only.

This FAQ expands upon the OHA Flexible Services Brief, provides examples of what are and what are not flexible services, describes how CCOs might implement flexible services, and describes how OHA incorporates flexible services into CCO payments. Additional guidance and technical assistance can be found on OHA's flexible services webpage.

This FAQ will be updated as additional questions are addressed. Please email questions to flexible.services@oha.oregon.gov.

Definitions

Flexible services are defined as 1) non-covered services under Oregon's Medicaid State Plan that are not administrative requirements, and 2) services meant to improve care delivery, and member and community health and well-being. The two types of flexible services are member-level and community-level flexible services as defined below.

Member-level flexible services are defined as cost-effective services offered to an individual CCO member to complement covered benefits.

Community-level flexible services are defined as community-level interventions focused on improving population health and health care quality. These initiatives include members but are not limited to member. These can also include certain investments in health information technology.

Changes in this January 2026 FAQ release

Updates were made throughout the FAQ to reflect the program name change from health-related services to flexible services. See this July 2025 memo to CCOs for more information about the program name change.

Criteria, inclusions and exclusions for flexible services

1. What are the criteria for being considered flexible services?

CCOs should refer to the criteria defined under Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845 and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151. Specifically, to be considered flexible services it must meet the following criteria:

- Be designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements;
- Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and
- Be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations.

In addition, the flexible services must meet at least one of the following criteria:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge
- Improve patient safety, reduce medical errors, and lower infection and mortality rates
- Implement, promote and increase wellness and health activities
- Support investments related to health information technology and meaningful use requirements necessary to accomplish the activities above that are laid out in 45 CFR 158.151, which promote clinic community linkage and/or referral processes or support other activities as defined in 45 CFR 158.150

2. Are there exclusions to what can be considered flexible services?

Yes. CCOs have the flexibility to identify and provide flexible services beyond examples cited in the Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845 and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151. However, the following investments and activities are excluded from flexible services because they do not meet the definition of "improving health care quality" in CFR:

- Those that are designed primarily to control or contain costs;
- Those which otherwise meet the definitions for quality improvement activities but were paid for with grant money or other funding separate from premium revenue;
- Those activities that can be billed or allocated by a provider for care delivery (and therefore are reimbursed as clinical services);
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets

adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;

- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- All retrospective and concurrent utilization review;
- Fraud-prevention activities;
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- Provider credentialing;
- Marketing expenses;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Additionally, based on prior OHA guidance, the following are also excluded from flexible services:

- Administrative activities to support the delivery of covered services
- CCO and clinic staff time on administering flexible services (see also question 10 for additional details on staff costs)
- Community partner staff time for activities not associated with flexible services (see also question 11 for additional details on staff costs)
- CCO contractual requirements, such as ensuring an adequate provider network, required care coordination for covered services, or establishing and supporting a CCO community advisory council
- Provider workforce or certification training (see also question 19 for additional details on workforce training)
- Broad assessments or research, as it does not directly or on its own improve member and/or community health or health care quality

- Advocacy work that does not directly improve member and/or community health or quality of health care
- Marketing and promotional materials of CCO services or products that are distributed to the broader community and are not considered member health education materials
- Capital investments in new housing structures or in new structures that will provide OHP covered services

3. Can flexible services be used to provide clinical services?

Yes. As long as the service is not an OHP covered service for that member, and the service meets the other criteria under OAR 410-141-3845, it can be flexible services. Covered services are prohibited by federal rule and Oregon's 1115 OHP Demonstration Waiver's standard terms and conditions from being flexible services. It is also helpful to understand how OHA applies the terms "**covered services**" and "**billable services**" to flexible services:

- In federal rule, 45 CFR 158.150(c)(4) excludes from flexible services "Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services." OHA interprets this to mean that services that are reimbursed as clinical services because they meet the definition of covered services are not flexible services. OHA does not interpret this to exclude "billable" services from flexible services. Thus, covered services are not the same as billable services when applied to flexible services.
- **Covered services** are services described in CCO contracts and in Oregon's Medicaid State Plan as being part of the benefits that CCOs are required to provide to their members. flexible services are a complement to covered services.
- **Billable services** generally describe whether a facility or provider currently has the necessary licensing and Medicaid provider enrollment status to perform

Medicaid billing functions. Whether a CCO member is eligible for covered services is not affected by whether a provider can (or wants to) bill Medicaid.

- A medical setting that provides covered services for some members could also provide flexible services, but only for services that are not covered for the receiving members. Restrictions on staffing costs (see question 10) still apply.

Examples

- A CCO's community partner provides no-cost dental exams and sealants to OHP members at a community health fair. **These are covered OHP services and cannot be flexible services.**
- A CCO's community partner provides no-cost dental exams, sealants, oral health education, and oral hygiene supplies to public schools in low-income neighborhoods. The CCO's own data shows that 30% of children in those public schools are OHP members. The CCO could fund the program's services through **community-level flexible services but must** subtract the costs for the OHP covered services to the OHP members (30% of the costs of the services that are OHP covered).
- A dental clinic regularly provides OHP covered services to a CCO member. The member needs an additional service that is not covered under OHP and meets flexible services criteria. The CCO could pay for that non-covered service and report that cost as **member-level flexible services**.

4. How do flexible services intersect with the Prioritized List, and can flexible services be considered for denied clinical services?

Some services may be denied because they are below the funding line, don't meet criteria of a Health Evidence Review Commission (HERC) guideline, or are considered cosmetic, experimental or not medically necessary/appropriate. Those types of services can be considered flexible services if they meet other flexible services criteria. In general, services billed by licensed, enrolled providers using HIPAA-

compliant claims are medical services. However, if the services are not covered benefits under OHP, then they may be considered flexible services if they meet all other flexible services criteria. See also question 3 above for more details on "billable services" versus "covered services."

Note that a CCO may also pay for a denied service through a medical review exceptions process. This is reported as a medical loss and cannot be reported as flexible services.

5. Can flexible services be used to address the social determinants of health (SDOH)?

Yes. The goals of flexible services are to promote the efficient use of resources and address members' SDOH to improve health outcomes, alleviate health disparities, and improve overall member and community well-being.

6. How are flexible services related to value-based payments (VBPs)?

A non-covered service could be flexible services or could be part of a VBP arrangement, depending on how the CCO agrees to pay for the service. For example:

- If a clinic is contracted to provide services to a member through a capitated VBP arrangement with a link to quality, and chooses to include goods/services not covered under Medicaid as a part of their treatment, **those costs are considered part of a VBP, not flexible services**.
- If a clinic is not receiving a capitated VBP for a CCO member, they could request the CCO provide funding for goods/services not covered under Medicaid, and the CCO **could report those costs as flexible services**.
- If a clinic has a capitated VBP arrangement, they could request funding for goods/services not covered under Medicaid. The CCO **could report those costs as flexible services if the value of the service is not included in the VBP payment**. A CCO must report the value of goods/service as either flexible services or VBP, but not as both.

7. Can community-level flexible services fund pilot initiatives and long-term initiatives?

Yes. CCOs have the flexibility to identify and provide community-level flexible services that are pilot initiatives or long-term initiatives, as long as the service meets all other flexible services criteria.

Flexible services and other CCO spending mechanisms

8. How is flexible services spending different from in lieu of services (ILOS) spending?

Flexible services are non-covered services that are offered as a complement to covered benefits under Oregon's Medicaid State Plan while ILOS are optional services determined by OHA to be medically appropriate and cost-effective substitutes for covered benefits under Oregon's Medicaid State Plan.

There are specific Center for Medicare and Medicaid Services (CMS) and OHA approved ILOS options in the CCO contract. For example, a community health worker (CHW) providing preventive medicine counseling for members with chronic conditions in lieu of preventive medicine counseling in a clinic setting. CMS must approve an ILOS before it can be included in CCO contract and offered to members. Guidance on ILOS is available on OHA's ILOS webpage, which includes a flexible services and ILOS comparison. Additional ILOS details are available in the CCO contract, Oregon's 1115 Medicaid Demonstration Waiver and 42 CFR 438.3(e)(2).

9. How is flexible services spending different from the Supporting Health for All through REinvestment (SHARE) spending?

Flexible services are an **optional** way for CCOs to use their global budgets to address SDOH, including members' health-related social needs. SHARE **requires** a portion of CCOs' profits be reinvested in their communities to improve member and community health. SHARE investments are required to address upstream factors that impact

health (for example, housing, food and transportation). That is, while CCOs **may** use dollars from their global budgets to fund flexible services, CCOs **must** spend some of their profits on SHARE when the CCO meets certain financial requirements.

While SHARE dollars may fund the same types of activities and initiatives as flexible services, SHARE spending does not qualify as flexible services for the purposes of reporting or capitation rate setting and flexible services spending cannot count as part of the CCO's SHARE designation.

For more information on SHARE spending, see OHA's SHARE webpage, which includes an flexible services and SHARE comparison document.

Flexible services use cases

Questions 10–19 below address eligibility questions about common flexible service use cases. For additional guidance, see common categories and examples of flexible services spending in the examples of past-approved flexible services spending.

10. Can flexible services be used to fund staff?

No, flexible services must exclude CCO or clinic staff costs.

For non-CCO and non-clinic staff, the salary or hiring costs for staff are also generally excluded from flexible services because they are the cost of administering flexible services and not the services themselves. CCOs may report the full cost of flexible services service, and they are encouraged to always report flexible services spending in terms of the services provided and not in terms of staffing costs (including staff benefits, bonuses, etc.).

11. Can flexible services be used to cover over-the-counter (OTC) medications or durable medical equipment (DME)?

Flexible services can be used for OTC medications if they are not covered by the CCO and meet flexible services criteria, regardless of whether the condition is funded or unfunded. Flexible services can be used for DME when the item is not covered through OAR 410-122-0080(20), which requires medical appropriateness for

the member. However, there are no absolute exclusions to DME, and there is an exceptions process in OAR 410-122-0080(20) that can be utilized instead of flexible services.

12. Can flexible services be used to fund paramedic services?

Flexible services can only be used for the services that are not covered services or part of required care coordination. For example, assessing housing safety, transportation that does not qualify as non-emergent medical transportation, or navigation for non-covered services may meet flexible services requirements. Reporting in Exhibit L financial template should clearly describe the services being provided and who is receiving the services to help assess whether the services meet flexible services criteria, or whether they are covered services. Additionally, funding paramedic staff would not be flexible services. Generally, staffing costs are not considered flexible services (see question 10).

13. Can flexible services be used to purchase mobile hot spots, internet service and tablets for social service agencies?

Yes. Flexible services could be used to purchase mobile hot spots, internet service and tablets for social service agencies as long as 1) the agencies' services align with flexible services criteria and are not covered services, and 2) the technology is necessary for those services to be provided. However, providing this technology to a clinic that provides covered services would not be flexible services. In this case, the required technology would be considered an administrative expense.

14. Can flexible services be used to fund gaps in eligibility for other social services or Medicaid covered services?

Yes. If a member is applying to receive items or services through an OHP benefit, such as medical infant or child formula or oral nutrition supplements, member-level flexible services can be used to cover the cost before there is a formal program decision. Likewise, if a member is applying for eligibility for social services outside of

OHP, member-level flexible services can be used until the member becomes eligible for the regular receipt of that social service.

For example, if CCO members are leaving a hospital care setting and will be newly eligible for Long Term Services and Supports provided by DHS, or housing assistance through Oregon Housing and Community Services, member-level flexible services can be used to meet the members' needs until an eligibility determination is made.

15. Can flexible services continue to include housing, food and climate device services with the recently implemented health-related social needs (HRSN) covered benefits from the 2022–2027 1115 OHP Demonstration Waiver?

Flexible services can continue to include housing, food, climate device and other services to meet members' health-related social needs. Only those services that become covered HRSN benefits for eligible OHP members will no longer be eligible for flexible services. For example, if a CCO provides short-term rental assistance to a CCO member, it must be excluded from flexible services if that member meets eligibility criteria for the HRSN rental assistance benefit. There is a Housing and Medicaid Spending Programs guidance document available and more information about HRSN benefits is on OHA's HRSN webpage.

16. Can flexible services support community-based activities, such as a farmers market in a food desert or a houseless shelter?

Yes. Community-level flexible services are interventions that may include members and non-members and are focused on improving population health. Supporting food access in a food desert or a houseless shelter can be community-level flexible services as long as the specific funded activities meet the flexible services criteria in question 1.

17. Can CCOs use flexible services for advertising, corporate sponsorships or other activities that are not listed in OAR 410-141-3845?

No. Flexible services must meet specific criteria as outlined in Oregon administrative rule, and these activities do not meet those criteria.

18. Can flexible services be used to fund capital investments in new buildings for providing medical or imaging services?

No. Capital investments in new facilities designed to provide billable health services are considered administrative expenses. OHA's flexible services requirements distinguish between normal administrative costs and spending that is directly related to improving members' health. Capital investments and the costs of creating the physical and administrative structure to bill for covered services are administrative costs, not flexible services.

19. Can flexible services be used to support provider workforce training?

No. Flexible services guidance excludes provider workforce training because it is an administrative expense. This exclusion applies to all aspects of provider workforce training, including provider network development, recruitment, education, training, materials, incentives, benefits and bonuses for providers (or individuals the CCO intends to become providers through the spending) performing any Medicaid covered services. There is an exception for health information technology (HIT) related provider incentives as described in OHA's Flexible Services and HIT guidance.

However, funding educational scholarships for students as part of an equity strategy may qualify as flexible services if the scholarships do not result in provider qualification or certification for a future provider contract (or subcontract) with the CCO to provide covered services.

While not flexible services, there are other OHA supports to increase provider network capacity. The OHA Health Care Provider Incentive Program offers various

incentives, such as loan repayment, loan forgiveness and insurance subsidies to both students and providers who commit to serving patients in underserved areas of the state. More information is available on the OHA Health Care Provider Incentive Program webpage and the OHSU Office of Rural Health's Provider Incentive Programs webpage. Please contact the OHA Health Care Provider Incentive Program team (providerincentives@odhsoha.oregon.gov) with any questions.

Member access to flexible services

20. What is a CCO's responsibility to share flexible services information with members and the community?

CCOs are required to have flexible services policies and procedures in place that meet OHA requirements in OAR 410-141-3845 and CCO contract.

OAR and contract require that the policies and procedures encourage transparency, support provider and member engagement, and do not create undue burden for members, member advocates or providers requesting flexible services. This includes providing information about flexible services in alternate languages and formats.

In addition to the required flexible services policies and procedures, CCOs must also provide information about flexible services and how to request it in their CCO member handbooks.

21. Does the member's primary care provider or a clinician need to approve a member-level flexible services request?

No. The CCO must approve the member-level flexible services request, but clinical approval is not required by OHA. OAR 410-141-3845 states that member-level flexible services must be consistent with a member's treatment plan as developed by the care team and agreed to by the CCO. However, it does not specify that the

care team include the primary care provider or clinician, or that the care team approves the flexible services request. Additionally, these services should be documented in the treatment plan whenever possible, but this is also not required.

22. What is a CCO's responsibility to a member when a member-level flexible services request is refused?

CCOs are required in rule, OAR 410-141-3845(4)(a), to provide members with a written notification of a refusal to an member-level flexible services request. The CCO must also give a copy of the notification to any representative of the member and any provider who was a part of the member's request or requested on the member's behalf. The written notification must also share information about the member's right to file a complaint in response to the outcome.

If a member-level flexible services request is refused because other Medicaid or community resources are available for the same service or item, CCOs are strongly encouraged to inform the member or requester of the availability of those resources and coordinate a referral whenever possible.

23. Are CCO A members the only CCO members eligible to receive flexible services, or are any CCO member types eligible?

Any decision to fund flexible services is at the discretion of the CCO that administers the contract with OHA and that receives a global budget to manage the care of its member population. Additionally, OHA has not restricted CCOs from providing flexible services based on CCO member type.

Implementing, tracking and reporting flexible services

24. Can OHA pre-approve CCO flexible services spending?

While OHA cannot provide official pre-approval for CCO flexible services spending, OHA can provide feedback on whether spending descriptions align with flexible

services criteria and OHA published flexible services guidance. If spending does not align, OHA can also provide feedback as to why it does not align.

Official approval only happens during the annual OHA review of CCO flexible services data that is submitted in the annual Exhibit L financial template. If a CCO has received OHA feedback on a flexible services spending description before the annual submission, but that prior description does not match the one in the annual submission, OHA must use the annual submission description to determine if the spending counts as flexible services.

CCOs can ask flexible services questions and request flexible services feedback at any point by reaching out to the flexible services team at flexible.services@oha.oregon.gov, attending quarterly flexible services office hours, which are posted to the flexible services webpage, and using the optional flexible services data submission in the Quarter 2 Exhibit L financial template submission. Note that the flexible services team tries to respond to feedback requests within one to three business days but may require up to two weeks for feedback requests that include multiple flexible services spending descriptions.

25. Can OHA provide multiyear approval for CCO flexible services spending?

Yes. When CCO flexible services funds programs or projects for multiple years, the CCO can request multiyear approval.

26. How long does a multiyear approval from the flexible services team last?

If there is no change in the scope of services **and** the CCO submits the required annual updates and confirmations, multiyear approval lasts until:

- The end of the next CCO procurement period; **or**
- The year prior to a new service becoming covered and required in CCO contract, if the approved flexible services include that service. For example, some nutrition services became covered services in January 2025. Multiyear approval for flexible services that includes those nutrition services was through

2024. Flexible services reporting for the same program in 2025 should reflect only spending that is for non-covered services. Similarly, some housing services became covered services in November 2024, so multiyear approval for flexible services that includes those housing services were only through 2023.

27. What types of flexible services can receive multiyear approval?

Multiyear approval is appropriate for community-level flexible services, including HIT investments, that are funded over multiple years and will not change the scope of services throughout the funding timeframe. It is also appropriate for large member-level flexible services programs that are reporting spending in aggregate and will not change the scope of services throughout the funding timeframe. See the Exhibit L Flexible Services Guidance for reporting details.

28. Can pilot projects or project implementation receive multiyear approval?

Yes. For pilot projects, the CCO should report how the project may expand in the coming years without a change in scope of services. For example, adding new funding recipients, adding service locations, and/or increasing the number of community members receiving the service. For initial implementation of a project, the CCO should report how the funding supports both implementation and maintenance. Maintenance includes the long-term services and activities being funded once the project has launched.

29. What constitutes a change in scope of services that requires a new multiyear approval request?

Changes in services include, but are not limited to, adding new services and adding new priority populations that receive the services. For example:

- The flexible services funding supports a program that teaches social-emotional health in public schools and the program adds a physical activity promotion component.

- The flexible services funding supports a program that prioritizes children and families in low-income neighborhoods and the program begins to also prioritize elders.

The following changes do **not** require a new multiyear approval:

- Removing or reducing a set of services
- Narrowing who is prioritized to receive the services
- Increasing the number of service recipients without adding new priority populations that receive the services

CCOs are encouraged to reach out OHA's flexible services team (flexible.services@oha.oregon.gov) well ahead of the annual review process to discuss the changes in scope, ask questions about how to update and request a new multiyear approval, and get feedback on updated reporting language. Note that the flexible services team tries to respond to feedback requests within one to three business days but may require up to two weeks.

30. If the CCO has a multiyear agreement with a community partner, is the CCO required to pay the partner the total flexible services funding amount up front once receiving multiyear approval?

No. The CCO's flexible services reporting in Exhibit L (Report L6.21 and L6.22) is meant to capture the amount of money spent in the calendar year for flexible services and should match the agreement language between the CCO and the receiving entity. If the agreement is to pay a disclosed amount each year, that amount should be reported in each year spent.

31. Do the CCO's community advisory council (CAC) and Tribes need to participate in the approval of all community-level flexible services?

Although CCOs are required by rule and contract to develop a role for their CACs and for Tribes in community-level flexible services decisions, that role does not

require that CACs and Tribes participate in decisions for **all** community-level flexible services. The CCO needs to follow its own flexible services policies in determining who needs to be part of each community-level flexible services decision.

32. What are CCO reporting requirements for flexible services spending?

CCOs are required by contract to have written policies and procedures for administering flexible services that meet OHA requirements published on the flexible services webpage.

CCOs are also expected to report on flexible services spending in the annual Exhibit L financial template submission. Only CCO flexible services spending reported, and reviewed and approved by the OHA flexible services team, can be considered in the CCO performance-based reward financial incentive calculation.

Full flexible services reporting instructions are in the Flexible Services and Exhibit L Reporting guidance.

33. Can CCOs rely on published studies to support the use of flexible services, or will CCOs be expected to provide organization- and population-specific data?

CCOs are not expected to provide organization- and population-specific data to support the use of flexible services. CCOs may use existing evidence-based best practices, promising practices, research findings, or guidelines issued by government agencies, medical associations or national health care quality organizations to as evidence to support flexible services. In addition to other resources a CCO may identify, OHA has provided a list of potential sources for published studies or evidence to support flexible services on the flexible services webpage.

34. Is a positive return-on-investment (ROI) required for flexible services?

No. CCOs are not required to have or report a positive ROI for flexible services and the ROI reporting field is no longer included in the Exhibit L financial template.

However, CCOs may choose to use ROI data or evidence to evaluate flexible services. OHA has identified the following resources to support CCOs in calculating flexible services ROI.

- Commonwealth Fund ROI Calculator: This calculator is designed to help health systems and their community-based organization partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost patients. To help users of this ROI calculator, the Commonwealth Fund has provided a summary assessment of available evidence of health care impact for interventions related to addressing health-related social needs for high-need adults.
- Center for Health Care Strategies ROI Forecasting Calculator: This web-based tool is designed to help Medicaid state agencies, health plans and other stakeholders assess and demonstrate the cost-savings potential of efforts to improve quality.

35. How should the CCO report flexible services funded by quality pool funds?

CCOs are responsible to fill out the Exhibit L financial template in a way that results in no duplication across report tabs. The flexible services funded by quality pool funds may be reported in the flexible services L6.21 OHP tab instead of the Quality Pool L17.1 tab but cannot be reported in both tabs. Reporting that flexible services spending in the L6.21 tab may result in the appearance that the quality pool dollars have not been 100% distributed, but this can be explained in the narrative field for the quality pool in the L17 tab. For example, if 5% of the quality pool dollars were expended as flexible services, the CCO could note that 3% of quality pool dollars were expended as community-level flexible services and 2% as member-level flexible services.

Additional questions or concerns related to the Exhibit L financial template should be directed to the actuarial service mailbox (actuarial.services@odhsoha.oregon.gov).

36. Can CCOs report matching funds provided by a CCO to a community partner as flexible services?

CCOs can count matching funds or braided funds the CCO provided to a community partner as flexible services if the services funded meet flexible services criteria.

Additionally, only CCO funds from the CCO's global budget can be reported as flexible services. Funds from other sources, such as foundations or government grants, cannot be reported as flexible services.

Flexible services considerations in rate development, medical-loss ratio and performance-based reward

37. How are flexible services considered within the medical loss ratio (MLR) calculation compared to rate development?

MLR is the proportion of premium revenues spent on clinical services and quality improvement. CCOs are required to meet the state's MLR standard of 85 percent. According to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F) that was finalized April 25, 2016, flexible services are reflected in calculating the MLR if they meet the requirements under federal rules (45 CFR 158.150 and 45 CFR 158.151).

Specifically, if spending on flexible services meets the criteria laid out above, that spending is reflected in the MLR calculation. CCOs' use of flexible services helps them meet the state's MLR standard. OHA annually reviews CCO reported flexible services spending to ensure it meets flexible services criteria. Reported spending that does not meet flexible services criteria are excluded as flexible services in the MLR calculation.

38. How are flexible services considered in rate development and related to performance-based reward (PBR)?

Flexible services are considered in development of the non-benefit load of the CCO's rate. The non-benefit load is an additional rate added on top of medical expenses; this may include administrative expenses, underwriting margin, performance-based rewards, and managed care organization tax. CCOs are expected to use flexible services to efficiently and effectively reduce costs and improve care over time.

As CCOs provide flexible services that are more cost-effective than State Plan services, the per-capita growth rate for capitation rates should gradually decrease over the waiver period. As reflected in the 2017 1115 Medicaid demonstration waiver, and continued under the 2022 1115 waiver, OHA has implemented a performance-based reward (PBR) initiative in rate setting for the 2020–2028 CCO contract cycle. The PBR is calculated as a part of the rate-setting process and is intended to counteract decreases in capitation rates, also known as premium slide, which might otherwise discourage flexible services spending. The PBR initiative rewards CCOs with a higher underwriting margin when costs are held lower, quality is maintained, and CCOs invest in qualified flexible services spending. However, spending that does not meet flexible services criteria are excluded from PBR.

39. Can CCOs expect any credibility adjustments based on CCO size in the consideration of flexible services in their rates?

No, OHA does not anticipate a credibility adjustment for flexible services spending but will be looking at reasonableness as it relates to the per-member-per-month equivalent and impact on the total non-benefit load percentage.

Resources

- OHA flexible services webpage
- OAR 410-141-3500 and OAR 410-141-3845
- 45 CFR 158.150 and 45 CFR 158.151
- OHA SHARE webpage
- OHA ILOS webpage
- OHA 1115 OHP Demonstration Waiver webpage

Contact

For comments and questions, please email the OHA flexible services team at flexible.services@oha.oregon.gov.

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Healthy Policy & Analytics Division
Transformation Center
421 SW Oak Street
Portland, OR 97204
Transformation.Center@odhsoha.oregon.gov
www.oregon.gov/oha/HPA/dsi-tc