Flexible Services, SHARE and ILOS Basics for OHA Staff: Review of Medicaid Spending Programs

Updated December 2025

Contents

Background

In partnership with OHA's Medicaid Division and Oregon's coordinated care organizations (CCOs), the Transformation Center manages three CCO programs that address members' and communities' SDOH-E needs. This includes CCOs' SDOH-E investments in community partners.

The Transformation Center is the hub for innovation and quality improvement for Oregon's health system transformation efforts to achieve better health, better care and lower costs for all. The Transformation Center identifies, strategically supports and shares innovation at the system, community and practice levels.

This document provides OHA staff an overview of three Medicaid spending programs that allow CCOs flexibility in addressing members' and communities' needs. This document includes program descriptions, implementation and timeline details, minimum requirements, community involvement, policies and program contact information.

Flexible services

Flexible services complement Oregon Health Plan (OHP) covered services to improve member and community health. 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 required to be limited to members. These can also include certain investments in health information technology.

Learn more about flexible services on the OHA flexible services webpage.

Program origins

Oregon's 1115 Medicaid Demonstration Waiver gives CCOs the flexibility, through an integrated global payment for each member, to offer flexible services to improve member health. These are known as member-level flexible services or sometimes called flex services or flex funds. Flexible services also include community-level investments. The current waiver sets criteria for

flexible services using Title 45 of the Federal code (45 CFR 158.150 and 45 CFR 158.151), while CCO Contract (Exhibit K, Section 9) and Oregon Administrative Rule (OAR 410-141-3845) set other flexible services programmatic requirements.

Program implementation and reporting

CCOs are not required to offer HRS, though all CCOs do. CCOs determine how they administer and distribute HRS. All flexible services spending must meet flexible services criteria in state and federal policy (details linked above).

CCO flexible services spending that OHA accepts as meeting criteria counts favorably toward the CCO's medical loss ratio (MLR) requirements and is included in their performance-based reward for CCO capitation rates. Minimum MLR requirements help ensure that CCOs spend a large enough proportion of their Medicaid budgets on member related services; for more details, see the Minimum MLR Rebate Calculation Report Instructions.

All CCOs offering flexible services must also have policies and procedures in place for flexible services implementation. A CCO's flexible services policies and procedures must:

- Promote alignment between flexible services and the CCO community health improvement plan (CHP) priorities;
- Ensure Tribes and CCO community advisory councils (CAC) have a role in community-level flexible services spending decisions;
- Encourage transparent and accessible flexible services information to members and the community; and
- Outline an accessible request process that does not create unnecessary barriers for requesters.

CCOs are required to report all flexible services spending in their annual Exhibit L Financial Report submission. Exhibit L is the annual financial reporting template for CCOs. There are two reporting opportunities for flexible services:

- **Optional** Quarter Two (Q2) submission: OHA reviews optional Q2 spending details against flexible services criteria and provides a single round of feedback to CCOs. CCOs may use that feedback to fine tune flexible services spending details before the annual

submission. CCOs may also request a meeting with the OHA flexible services team to ask questions about the OHA feedback.

- **Required** annual submission: OHA reviews the annual spending details against flexible services criteria and provides a single round of feedback to CCOs. CCOs may attend the flexible services team's reporting-specific office hours or reach out directly to the flexible services team with questions about the feedback. After that, CCOs have one opportunity to submit more information to OHA before OHA makes final determinations about spending meeting criteria. Flexible services spending that does not meet criteria is excluded from performance-based reward.

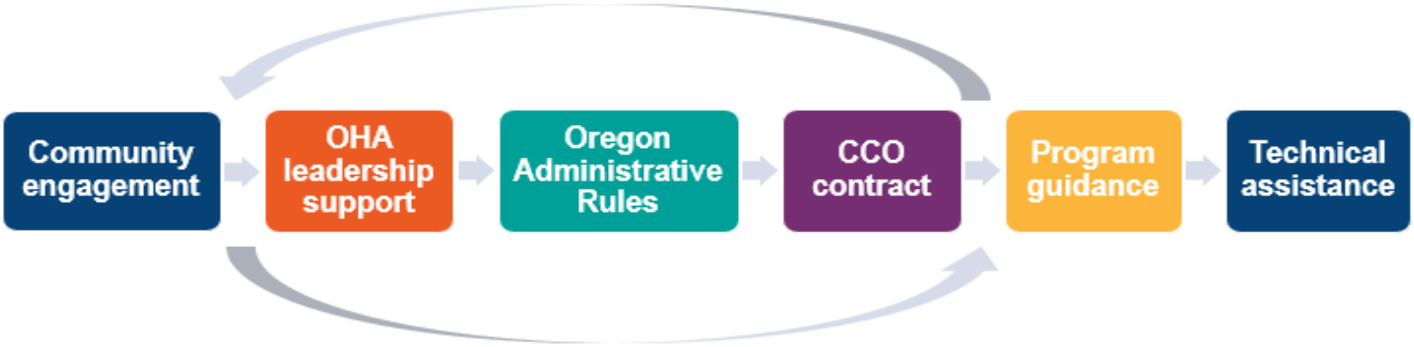
The Transformation Center publishes an annual CCO flexible services spending summary. This summary analyzes all CCO flexible services spending to increase transparency, alignment and collaboration. Flexible services spending summaries are available on the OHA flexible services webpage.

The Transformation Center offers technical assistance to CCO staff for program implementation. CCOs may choose to provide their own technical assistance to providers, care teams, government and social service agencies, and other community partners.

Program changes

Changes to flexible services are informed by input from members and providers, CCO staff and leadership, and OHA's Medicaid Advisory Committee, Ombuds Program and Office of Community Health and Engagement.

Centers for Medicare and Medicaid Services (CMS) must approve any changes to flexible services criteria or the parameters for including flexible services in MLR calculations and performance-based reward for capitation rate setting. The current pathway for changes to OHA flexible services policy, CCO flexible services policy requirements and CCO flexible services reporting requirements is:



Community engagement includes: CCO feedback collected through various CCO work groups led by OHA, office hours, direct communication with OHA flexible services team, webinars and technical assistance. Provider and member feedback is collected through direct communication with the OHA flexible services team, through member advocates and the Ombuds Program.

Key links and program contacts

View the OHA flexible services webpage for the most recent, detailed guidance about program implementation.

Send questions to flexible.services@oha.oregon.gov.

Supporting Health for All through REinvestment (SHARE)

Supporting Health for All through REinvestment (**SHARE**) comes from a state legislative requirement for CCOs to invest some of their net income or reserves back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and SDOH-E.

SHARE spending must be aligned with community priorities from the CHP, include a decision-making role for the CAC and address SDOH-E efforts. Learn more about SHARE on the OHA SHARE webpage.

Program origins

In 2018, House Bill 4018, Section 3, 1(b)(C) required CCOs to spend a portion of annual net income or reserves that exceed minimum financial requirements on addressing health disparities and social determinants of health consistent with the CCO's CHP. In 2019, Senate Bill 1041, Section 57, 1(b) modified minimum financial standards used to determine CCOs' SHARE participation. OAR 141-414-3735 set SHARE definitions and requirements, including the formula used to calculate CCOs' minimum SHARE obligation.

The Oregon Health Policy Board set the statewide priority area for SHARE, currently housing-related supports and services. The Medicaid Advisory Committee created the definitions of "social determinants of health" and "social determinants of equity." These groups informed how the SHARE program was implemented.

Program implementation and reporting

A CCO's SHARE dollars must:

- Align with community priorities in the CCO's current CHP;
- Include any statewide priorities for SHARE spending that are identified in the contract between CCOs and OHA (currently housing);
- Include a decision-making role for the CCO's CAC;
- Involve community partnerships, with a portion of dollars going to SDOH-E partners; and
- Support SDOH-E efforts, defined by OAR 141-414-3735.

The amount CCOs must spend on SHARE (known as their SHARE obligation) is determined after a CCO exceeds minimum financial reserve requirements. The required amount is calculated from either a percentage of average adjusted net income or a portion of their dividends paid. For more detail, see the SHARE Guidance for CCOs. CCOs may also spend more than what's required.

After CCOs decide how much to spend on SHARE (called their SHARE designation), CCOs determine how to implement and administer SHARE funds, along with what resources or support for community partners they offer. Some CCOs offer competitive grant funding opportunities with SHARE funds, while others support community partners using more targeted outreach.

SHARE has two annual CCO reports:

1. **SHARE spending plan/attestation:**
    - In 2021−2024, CCOs required to participate in SHARE submitted an annual SHARE spending plan. The plan included: which SDOH-E partners will receive SHARE funds, what projects or activities the funds will be used for, which SDOH-E domains the projects address, and how funding decisions were made, including the CAC's

role and CHP alignment. SHARE spending plans are available on the OHA SHARE reports webpage.

- Starting in 2025, CCOs attest to meeting the SHARE requirements, which includes briefly describing the planned investments (partner names, activities being funded and dollar amounts).
- Starting in 2026, CCOs are also required to publicly post information about their SHARE investments on their CCO's website.

2. **SHARE spending report:** SHARE spending reporting is integrated in Exhibit L (L6.71). Because CCOs have three years to spend down each year's SHARE contribution, the reports may not reflect the full funding from any one year's spending plan. If CCOs weren't required to participate or didn't spend any SHARE funds in a given year, they are not required to submit a spend-down report in the next year. More details are available on the OHA SHARE reports webpage.
    - Exhibit L (L6.7) also includes the SHARE formula, where CCOs calculate their obligations and report their designations.

The Transformation Center manages SHARE. This has included review, feedback and approval of CCOs' annual SHARE reporting and annual guidance and reporting updates. The Transformation Center has also provided CCO technical assistance, including publishing an annual summary of CCO SHARE spending. The goals of this summary are to increase transparency and awareness of CCO community spending and provide CCOs with examples to support future SHARE spending.

Technical assistance has included office hours, one-on-one consultation, webinars, learning collaboratives, peer sharing and convenings.

Program changes

Changes to SHARE depend on the type of change.

- **Program direction:** Legislation could require changes to the program.
- **Program definitions and requirements:** The Rules Advisory Committee process could change the SHARE definitions or the SHARE formula in Oregon Administrative Rule.

- **Reporting or deadlines:** CCO contract change or guidance updates from OHA could change reporting requirements or deadlines.

Changes to SHARE may start at different steps depending on the type of change, but follow this pathway:

Key links and program contacts

View the OHA SHARE webpage for the most recent, detailed guidance about program implementation. CCOs' SHARE reports can be found on the SHARE reports page.

Send questions and feedback to Transformation.Center@odhsoha.oregon.gov.

In lieu of services (ILOS)

In lieu of services (ILOS) are medically appropriate and cost-effective substitutes for covered benefits under the State Medicaid Plan. ILOS must meet federal requirements outlined in 42 CFR 438.3(e)(2). ILOS available for CCO implementation are outlined in CCO contracts with OHA.

- ILOS are typically provided in alternative settings and/or by alternative providers.
- ILOS are meant to promote access to services in culturally responsive ways.
- ILOS can be an immediate or longer-term substitute.
- CCOs are not required to offer ILOS to members.
- CCO members are not required to use ILOS.

Program origins

ILOS was first approved for use in Oregon in 2022 and first available for CCO implementation in 2023. ILOS is defined in Federal Law (42 CFR 438.3(e)(2)); CCO contracts (Exhibit B, Part 2,

Section 11); and must be consistent with provisions in Oregon Administrative Rule (OAR 410-141-3820).

ILOS connects to OHA's larger vision for health system transformation:

- Improving access to services in a more culturally responsive manner;
- Enhancing care coordination for high-need or traditionally underserved members; and
- Reducing hospital care, nursing facility care and emergency department use.

Program implementation and reporting

ILOS must be approved by the state and by CMS. The most recent list of approved ILOS in Oregon, which is included in CCO contracts, is available in the ILOS Program Overview. See "Program changes" below for details on the ILOS development and approval process.

CCOs may choose to offer one or more of Oregon's approved ILOS to their members, but they're not required to. CCOs are encouraged to work with their clinical and community-based partners to determine which ILOS may be appropriate and useful to their members.

Before ILOS is offered to members, CCOs must meet certain implementation requirements outlined in CCO contract, like including the service(s) in their member handbook and notifying members appropriately. Other necessary steps include contracting with ILOS providers, adding them to provider directories and setting up billing and reporting processes. CCOs may choose to offer any approved ILOS at any point in a calendar year after implementation requirements are met.

ILOS can offer some flexibility in what and how billing information is collected from ILOS providers without infrastructure to submit traditional Medicaid claims. Regardless of the billing pathway used, CCOs must submit valid encounter data for ILOS. CCOs are also required to report aggregate ILOS spending information annually to OHA through the Exhibit L Financial Report, Reports L6, L18 and L18.1. OHA considers each CCO's ILOS utilization and costs in developing the medical component of their capitation costs. Learn more about ILOS billing and reporting in the ILOS billing and reporting guide on the OHA ILOS webpage.

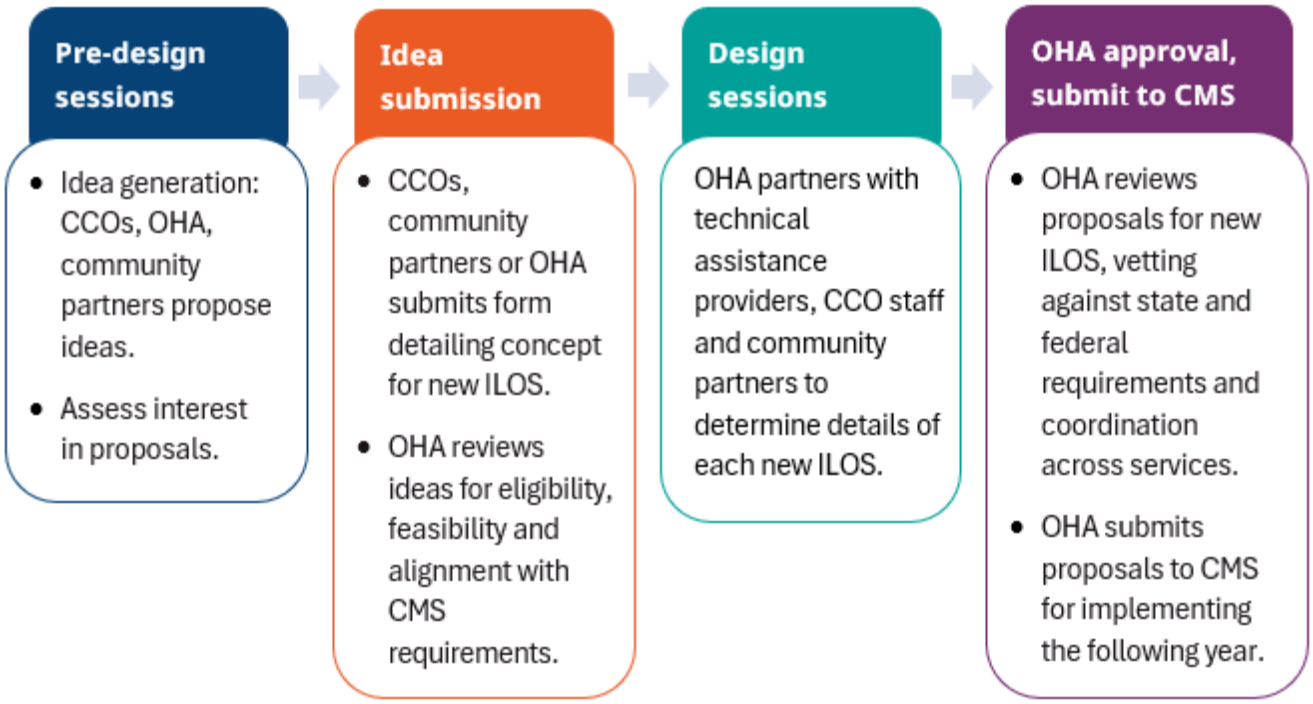
The Transformation Center offered technical assistance to CCOs to support ILOS implementation. This has included webinars, office hours, guidance documents and topic-specific design sessions.

Program changes

There are two primary ways the ILOS program can change: changes to program definitions and requirements or changes to Oregon's approved ILOS available for CCO implementation.

- **Changes to program definitions and requirements:** Federal changes to ILOS program definitions and requirements could occur at any time from CMS, impacting Oregon's and CCOs' understanding and implementation.
- **Changes to Oregon's approved ILOS:** Annually, OHA can propose changes or additions to Oregon's approved ILOS to CMS. Proposed changes are developed collaboratively with OHA staff, CCOs, community partners and technical assistance providers in a process called ILOS design. The process of ILOS design typically includes the elements below.

ILOS design session elements



The design and approval process usually takes just over a year for a new ILOS to become available. For example, if pre-design sessions begin in November 2024, the new ILOS could be available at the start of 2026. ILOS approved by CMS are included in CCO contracts.

Key links and program contacts

View the OHA ILOS webpage for the most recent, detailed guidance about program implementation. ILOS technical assistance opportunities and resources are available on the ILOS technical assistance webpage.

See clarifying guidance from CMS on ILOS principles (2023).

Send questions to ILOS.info@odhsoha.oregon.gov.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Transformation Center at Transformation.Center@odhsoha.oregon.gov or 503-487-7409, 711 TTY. We accept all relay calls.

Health Policy and Analytics Division
Transformation Center
Transformation.Center@odhsoha.oregon.gov
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/index.aspx