# Flexible Services Brief

December 2025

## Contents

# Background

In 2012, with Oregon's 1115 Medicaid Demonstration Waiver (the Waiver), the state began to transform its Medicaid delivery system by creating coordinated care organizations (CCOs). The CCOs were required to integrate and coordinate care and meet key quality metrics tied to financial incentives. The Waiver gave CCOs the flexibility, through an integrated global payment for each member, to offer flexible services to improve member health. Through the subsequent Waivers, flexible services were defined to include both member- and community-level services.

Flexible services are defined as non-covered services under Oregon's Medicaid State Plan that are not administrative requirements and are meant to improve care delivery and overall member and community health and well-being. One of the purposes of flexible services is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH), including the health-related social needs of their members. For CCOs to use federal Medicaid funds to pay for flexible services, they must comply with state and federal criteria.

The purpose of this brief is to define flexible services, describe the use of flexible services among CCOs, and explain how flexible services are incorporated into CCO payments. Additional guidance and technical assistance around flexible services, including an FAQ to support CCO flexible services implementation, can be found on OHA's flexible services webpage.

# What counts as flexible services

## 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 supplement 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.

## Criteria

CCO flexible services spending must meet the definition above and requirements in the Waiver's standard terms and conditions. Those requirements state that CCO flexible services spending must meet the criteria for **activities that improve health care quality** (45 CFR 158.150) **or** be spending related to **health information technology that improves health care quality** (45 CFR 158.151).

To count as activities that improve health care quality, the flexible services spending **must meet all four criteria**:

1. Be designed to improve health quality;
2. Increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements;
3. 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-enrollees; **and**
4. 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

The flexible services spending **must also meet at least one of these criteria:**

1. Improve health outcomes and reduce health disparities among specific populations;
2. Prevent hospital readmissions;
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates;
4. Implement, promote, and increase wellness and health activities; **or**
5. Enhance use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology

## Resources for evidence-based practices

For activities to 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" CCOs do not have to provide organization- or population-specific data. In addition to other resources a CCO may identify, OHA has identified the following resources as acceptable sources for published studies or evidence to support flexible services:

- **Centers for Disease Control and Prevention (CDC):**
  - CDC Health Impact in 5 Years (HI-5): Highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness or cost savings over population lifetime.
  - CDC Social Determinants of Health: Resources for social determinants of health data, tools for action, programs and policy.
- **Community Preventive Services Task Force Findings:** What works to promote healthy communities.
- **Healthy People 2030:** Resources, organized by domain, to help learn how communities across the country are addressing the social determinants of health.
- **Leveraging the Social Determinants of Health:** The Massachusetts Foundation's report on what works for interventions addressing social determinants of health.
- **Social Interventions Research & Evaluation Network (SIREN):** University of California, San Francisco's SIREN works to improve health and health equity by advancing high quality research on health care sector strategies to improve social conditions.

    - SIREN Evidence & Resource Library: Includes both peer-reviewed and other types of resources, such as webinars and screening tools/toolkits on medical and social care integration.
- **OHA Health Evidence Review Commission**: Multisector intervention reports on population-based health interventions or other types of interventions that happen outside of clinical settings

While a reporting a return on investment (ROI) is not required to meet flexible services criteria, OHA has identified the following ROI calculation resources for flexible services spending:

- 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.

## Exclusions from flexible services

CCOs have the flexibility to provide flexible services beyond the list of examples in the OARs and CFRs. However, the following activities are excluded from flexible services because the CFR excludes them from activities that improve health care quality. The excluded activities include:

1. Those that are designed primarily to control or contain costs.

2. Those which otherwise meet the definitions for quality improvement activities but were paid for with grant money or other funding separate from premium revenue;
3. Those activities that can be billed or allocated by a provider for care delivery (and therefore are reimbursed as clinical services);
4. 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;
5. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
6. All retrospective and concurrent utilization review;
7. Fraud-prevention activities;
8. 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;
9. Provider credentialing;
10. Marketing expenses;
11. Costs associated with calculating and administering individual enrollee or employee incentives;
12. That portion of prospective utilization that does not meet the definition of activities that improve health quality

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

1. Administrative activities to support the delivery of covered services
2. CCO and clinic staff time on administering flexible services

3. Community partner staff time for activities not associated with flexible services
4. 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
5. Provider workforce or certification training
6. Broad assessments or research, as it does not directly or on its own improve member and/or community health or health care quality
7. Advocacy work that does not directly improve member and/or community health or quality of health care
8. Marketing and promotional materials of CCO services or products that are distributed to the broader community and are not considered member health education materials
9. Capital investments in new housing structures or in new structures that will provide OHP covered services

## Financial incentives for CCOs to spend on flexible services:

CCOs use their global budgets to fund flexible services and are incentivized to provide flexible services through the minimum medical loss ratio (MLR) and performance-based reward (PBR). Expenditures that meet flexible services criteria are reflected in the MLR calculation and are included in the PBR calculation as part of the rate-setting process. This maximizes the federal financial participation in flexible services allowable under Oregon's Medicaid authority.

### Flexible services and the CCO MLR

An 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 expenditures for flexible services meet the definitions laid out above, these expenditures are reflected in the MLR calculation. CCOs' use of flexible services helps them meet the state's MLR standard. To determine if expenditures meet flexible services definitions, OHA annually reviews CCO reported flexible services. Expenditures that do not meet flexible services definitions are excluded from the MLR calculation

## Flexible services and CCO rates

Flexible services are reflected in the MLR if they meet the requirements under 45 CFR 158.150 and 45 CFR 158.151. They are also 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 efficiently and effectively reduce costs and improve care over time by using flexible services.

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 OHP 1115 demonstration waiver, and continued under the 2022 OHP 1115 demonstration waiver, OHA has implemented a PBR initiative in rate setting for the 2020-2024 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. Expenditures that do not meet flexible services definitions are excluded from PBR.

## Flexible services resources

- OHA flexible services webpage
- OHA Flexible Services FAQ
- OAR 410-141-3500 and OAR 410-141-3845
- 45 CFR 158.150 and 45 CFR 158.151
- OHA's 1115 OHP Demonstration Waiver website

## Contact

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

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