



Supporting Health for All through REinvestment: the SHARE Initiative

Background

The Oregon Health Authority (OHA) developed the SHARE Initiative to implement the legislative requirement in House Bill 4018 (Oregon Legislature, 2018) which aims to address social determinants of health. The SHARE Initiative begins in 2020.

The primary goals are to:

- Safeguard public dollars by requiring that a portion of CCOs' profits are reinvested in their communities; and
- Improve member and community health by requiring reinvestments go toward upstream factors that impact health (for example, housing, food, transportation).

The Oregon Health Policy Board's [CCO 2.0 policy recommendations](#) shaped SHARE Initiative requirements,ⁱ including:

Requirement 1: Spending must fall within 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 the Community Advisory Council(s) related to its SHARE Initiative funds.

This document will provide guidance on how CCOs can:

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

Additional guidance and definitions can be found in the CCO contract and [OAR 410-141-3735](#), and on [OHA's SHARE Initiative webpage](#).ⁱⁱ

How much of its annual profits is a CCO required to invest in the SHARE Initiative?

For the first two years of the SHARE Initiative — that is, CCOs spending a portion of profits from Contract Years (CYs) 2020 and 2021 — it is up to each CCO to decide how much of its profits it will contribute to the SHARE

Definitions

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 (SDOH-E, defined on page 2).

Health Equity: Health equity is 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.

SDOH-E Partner: A single organization, local government, one or more of the federally recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's Service Area.

Initiative. A CCO reports this amount as part of Exhibit L, Report L6.7. If a CCO does not exceed minimum financial reserve requirements for CCOs,ⁱⁱⁱ they are presumed exempt from the SHARE Initiative. OHA expects to set a formula to prescribe each CCO's annual SHARE Initiative requirement. This formula could be prescribed as early as CY 2022, and this guidance will be updated when a formula is developed.

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. For guidance on how CCOs may use their global budgets to address members' social needs and SDOH-E in their communities, visit OHA's [Health-Related Services \(HRS\) webpage](#) and see OHA's guidance document [Addressing Social Determinants of Health and Equity through Health-Related Services](#). While SHARE Initiative dollars may fund many of the same types of SDOH-E initiatives as HRS, SHARE Initiative spending **does not qualify** as HRS for the purposes of reporting or rate setting, and HRS expenditures may not be counted as part of the CCO's SHARE designation. Additionally, a CCO's SHARE Initiative spending will be excluded from its Medical Loss Ratio (MLR). Finally, SHARE Initiative spending will not be considered under the performance-based reward program.¹

SHARE requirement 1: SDOH-E domains

In 2017, Governor Brown outlined expectations for the CCO 2.0 contract which included four key areas for CCOs to address in order to improve member health - one of which was SDOH-E. The SHARE Initiative is one way in which a CCO may respond to SDOH-E. 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.
- 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 modified the Oregon Medicaid Advisory Committee definition of social determinants of health^{iv} to create a definition of SDOH-E in Oregon Administrative Rule (OAR 410-141-3735). This SDOH-E definition encompasses three different and interrelated terms as defined below: the social determinants of health (SDOH), the social determinants of equity (SDOE) and health-related social needs (social needs).

¹ Performance-Based Reward is a new program that will support CCO efforts to increase HRS spending to improve community health. The PBR will provide higher margins to CCOs that successfully invest in HRS, while maintaining quality and meeting cost-growth targets.

- ✓ **Social determinants of health:** 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:** 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:** An individual’s social and economic barriers to health, such as housing instability or food insecurity.

Each of these SDOH-E concepts plays a unique role in impacting individual and community health, and each requires different strategies to improve health. Individual-level efforts that address social needs, such as referrals to community health workers or social services, can address barriers to housing stability or social isolation and improve health. Community-level efforts can improve community health by addressing SDOH and SDOE directly through policy and systems change, such as efforts to increase supportive housing in a CCO’s community.

Four domains of SDOH-E for SHARE Initiative spending

As stated on page 2, in addition to meeting the general definitions above, SHARE Initiative spending should target at least one of four domains recommended by Oregon’s Medicaid Advisory Committee (MAC):^{v,2}

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

Below is a list of examples within each of the four domains, as well as examples of projects a CCO might support with SHARE funding. The list is not comprehensive.

Domain	Examples	Project examples
Economic stability	<ul style="list-style-type: none"> • Income/poverty • Employment • Food security/insecurity • Diaper security/insecurity • Access to quality childcare • Housing stability/instability (including homelessness) • Access to banking/credit 	<ul style="list-style-type: none"> • Provide financial supports to local organizations working to enact anti-poverty policies or land use policies that create or maintain affordable housing (for example, “tiny homes”) • Fund supportive or supported housing initiatives • Provide funds for new housing³

² Strategies targeted exclusively at “health and health care” are not included in these domains, although they are sometimes included in other definitions of social determinants of health, as these are core functions of CCOs and Oregon’s health care system. Dollars from the SHARE Initiative are meant to address needs beyond the “clinic walls” through community partnerships.

³ Because the SHARE Initiative uses annual net profits, funds can be used on some expenses not normally permitted in the Medicaid program, including room and board.

Neighborhood and built environment	<ul style="list-style-type: none"> • Access to healthy foods • Access to transportation (non-medical) • Quality, availability, and affordability of housing • Crime and violence (including intimate partner violence) • Environmental conditions • Access to outdoors, parks 	<ul style="list-style-type: none"> • Partner to support community enhancements, such as park improvements and bike lanes
Education	<ul style="list-style-type: none"> • Early childhood education and development • Language and literacy • High school graduation • Enrollment in higher education 	<ul style="list-style-type: none"> • Partner with early learning hubs to support parenting education and language and literacy courses • Partner to support high school completion programs, such as mentoring programs
Social and community health	<ul style="list-style-type: none"> • Social integration • Civic participation/community engagement • Meaningful social role • Discrimination (for example, race, ethnicity, culture, gender, sexual orientation, disability) • Citizenship/immigration status • Corrections • Trauma (for example, adverse childhood experiences) 	<ul style="list-style-type: none"> • Support programs designed to counter loneliness and social isolation • Fund traditional health worker (THW) programs, including programs in which THWs are stationed in key environments, such as housing communities
All domains	<ul style="list-style-type: none"> • Fund a medical legal partnership to support members with legal concerns related to housing, discrimination, immigration, and other areas • Fund community-based organization licenses and/or infrastructure to use community information exchange (CIE) platform 	

Statewide priority: Housing-related services and supports

Due to a statewide housing crisis and supported by feedback during the CCO 2.0 policy engagement period, the Oregon Health Policy Board identified housing-related services and supports as a statewide priority for at least the first two years 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. CCOs are encouraged to explore ways to use SDOH-E spending to support these initiatives, in collaboration with the community and their CAC, to guarantee the most effective and robust interventions possible.

Permanent supportive housing (PSH)

Additionally, in partnership with Oregon Housing and Community Services, OHA is supporting a statewide effort to increase PSH. PSH 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 homeless or at risk of becoming homeless and people who are institutionalized or at risk of institutionalization.

Examples of SHARE spending on housing-related services and supports

Housing-related services and supports can be offered at the individual level or at the community level. SHARE dollars come from a CCO’s annual net profits and are not considered in the medical loss ratio, as Health-Related Services, or otherwise in rate development. Because of this, Medicaid restrictions on funding room and board do not apply to these dollars.

Individual level:

- Services that address an individual’s housing-related need, such as housing instability. One example is individual assistance with a housing application process.
- Rental assistance

Community level:

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 enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported housing is scattered site supported housing, with no more than 20% of the units in any building to be occupied by individuals with a disability known to the State. 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 medical needs or substance abuse history.

Permanent supportive housing (PSH): PSH 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 homeless or at risk of becoming homeless and people who are institutionalized or at risk of institutionalization. PSH generally refers to a specific building or site dedicated to providing deeply affordable housing paired with housing supports.

- Contributing funds to efforts to build new PSH, tiny homes, or other initiatives to increase affordable housing in a CCO’s Service Area
- Working with local housing partners to increase PSH in the community. A CCO might guarantee health services in a supported/supportive housing community or might use surplus dollars outside of its global budget (non-Medicaid) to support the development of new housing in a community.
- Partnering with local housing organizations and/or community-based organizations to combat discrimination in housing communities.

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.

What does it mean for a SHARE spending priority to be “based on” shared priorities in the CHPs?

CCOs have been required to develop CHPs since 2012. More recently, the CCO contract and Oregon Administrative Rule ([OAR 410-141-3730](#)) require CHPs to be shared with local public health authorities, hospitals, other CCOs, and tribes. OHA developed [CCO Guidance: Community Health Assessments and Community Health Improvement Plans](#) to help CCOs meet this new requirement.

Until a CCO has a fully shared CHP, CCOs must identify spending priorities by looking at priorities in 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 requirement 3: SDOH-E Partners

The health care system is relatively new to addressing social factors like food, housing, and transportation that impact health. On the other hand, community-based organizations, social service agencies, and local health departments have been addressing SDOH-E for decades. 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 federally recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative;
- B) That 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 enough 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, CBOs and local health departments). Here are some examples of groups that would be considered SDOH-E partners:

- Nonprofit social and human service organizations (for example, organizations supporting economic opportunity; supporting individuals with disabilities; promoting safe housing, education, food security and environmental justice; and others)
- Culturally specific organizations
- Local public health authorities
- Regional health equity coalitions
- Local government and government-associated entities
- Tribal governments and the Urban Indian Health Program
- Early learning hubs
- Local housing authorities

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 must have a contract, which could include a grant agreement, or other agreement such as a memorandum of understanding (MOU) with each SDOH-E partner that receives SHARE funding. The CCO shall ensure that its written agreement with each SDOH-E Partner meets the following minimum requirements:

- Contract term and budget;
- Legal names for all entities;
- SDOH-E domain(s) in which the SDOH-E Partner provides services;
- How CCO will distribute funds to the SDOH-E Partner, including distribution schedule and allowable percentage of indirect costs;
- The scope of work to be performed, including:
 - Specific services to be provided; and
 - Which populations will be provided services (e.g., CCO Members, Community members, Tribal communities, communities of color, etc.).
- How outcomes will be measured and evaluated, including:
 - Specific, Measurable, Achievable, Relevant and Time-based (SMART) objectives; and

- How outcomes align with community priorities from the CCO’s Community Health Improvement Plan (CHP).
- Data collection, sharing, and reporting obligations of both the SDOH-E Partner and the CCO, including:
 - 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.

SHARE requirement 4: Community Advisory Council role

Each CCO has at least one Community Advisory Council (CAC), which includes CCO 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, and OAR 410-141-3735:

➤ The CCO is responsible for providing a role for its CAC related to the SHARE Initiative.

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 that are in line with community priorities in the CHP.
- The CAC reviews SHARE Initiative related 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 tracks and monitors outcomes of SHARE Initiative spending.

For general resources and resources related to CACs, visit: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx>

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. Reporting templates are provided on the [CCO Contract Forms webpage](#).

Report	Description	Due
Annual SHARE Initiative Designation Exhibit L, Report L6.7	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 for informational purposes, including: 1) annual risk-based capital prior to SHARE contribution; 2) annual pre-tax net income prior to SHARE contribution; and 3) dividends recorded.	April 30, annually; first report is due in 2021 for CY 2020

Annual SHARE Initiative Spending Plan	Includes SDOH-E priorities, partner information, proposed budgets and other information as required by contract	September 30 ⁴ , annually for CCOs with a SHARE Initiative designation; first plan due in 2021 for CY 2020 funds
Annual SHARE Initiative Spend-Down Report Exhibit L, Report 6.71	Annual report of year-over-year spend-down of SHARE funds	April 30, annually; first report due 2022 for CY 2020 funds
Annual SHARE Initiative Detailed Spending Report	Annual reporting of detailed SHARE spending to date. Submitted to OHA with the CCO's SHARE Initiative Spending Plan, if relevant, or submitted as separate report if the CCO is not required to submit a spending plan for that year.	June 30, annually for CCOs with any unspent/unreported SHARE funds; first report due in 2022 for CY 2020

Spending exclusions for SDOH-E

In general, SHARE dollars may be spent in a variety of ways as long as spending complies with the overall requirements as outlined 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:

- 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 for accessing preventive services);
- 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;

⁴ CCOs can submit their proposed Spending Plans at any time from 6/30/2021 through 9/30/2021. OHA will notify each CCO about the approval status of its plan within 30 days of receipt. In the event a CCO's plan cannot be approved as submitted, OHA will work with the CCO to resolve the identified deficiencies as quickly as possible.

- Advocacy specific to CCO operations and financing (as opposed to advocacy for policy that advances SDOH-E objectives); or
- Expenses that have been reported separately, such as Medicaid-covered services⁵ or health-related services.

CCOs are encouraged to contact OHA at SHARE.Initiative@dhsosha.state.or.us with questions about allowed and disallowed uses of SHARE dollars prior to allocating them to the use in question.

Conclusion

The SHARE Initiative is one way CCOs are addressing social determinants of health. SHARE Initiative spending is legislatively **required** for those CCOs that exceed financial requirements^{vi} and is spent from excess end-of-year profits, rather than premium revenue.

There are four requirements for a CCO's SHARE Initiative:

1. Spending must fall within SDOH-E domains and include spending toward a statewide housing priority.
2. Spending priorities must align with community priorities from Community Health Improvement Plans.
3. A portion of funds must go to SDOH-E Partners.
4. CCOs must designate a role for the Community Advisory Council(s) related to its SHARE Initiative funds.

CCOs will report their SHARE Initiative spending by submitting the annual financial and narrative reports outlined to OHA, as outlined in this document.

⁵ Certain Medicaid-covered services may also be used to address an individual's social needs. For example, CCOs coordinate with home and community-based service providers to address social needs of many of their dual-eligible members. Additionally, some behavioral health populations may be eligible for certain housing-supportive services through Medicaid. While certain covered services may be used to address an individual's social needs, these services do not qualify as SHARE Initiative spending, as they are already reported through existing financial reporting mechanisms.

References

ⁱ Policy #1, CCO 2.0 Recommendations of the Oregon Health Policy Board, Appendix A (2018). Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Appendix-A.PDF>

ⁱⁱ OHA HRS website: www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

ⁱⁱⁱ 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>

^{iv} 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

^v 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

^{vi} [House Bill 4018, Section 3, 1\(b\)\(C\)](#)