Supporting Health for All Through Reinvestment (SHARE)

2022 spending plan summary

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Oregon Health Authority

ORPRN
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Executive summary

Purpose of document

This document provides an overview of coordinated care organization (CCO) Supporting Health for All through REinvestment (SHARE) Initiative spending, with a goal of increasing transparency and awareness of CCO community spending statewide. The document also may provide CCOs with examples to support future SHARE Initiative spending. The SHARE Initiative is one way that CCOs respond to social determinants of health and health equity (SDOH-E), health inequities and the social needs of their members and communities. This summary does not reflect all CCO spending on social determinants of health, such as CCO spending through health-related services (HRS) or other CCO programs.

Definition of SHARE

The Supporting Health for All through REinvestment (SHARE) Initiative comes from a legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on efforts to address health inequities and SDOH-E. SHARE Initiative spending must align with community priorities, include a role for the CCO community advisory council (CAC), be administered through partnerships with community organizations or agencies (called SDOH-E partners), and fit within OHA's pre-defined spending domains – economic stability, neighborhood and built environment, education, and social and community health.

SHARE Initiative reporting

CCOs submit an annual spending plan for SHARE by December 31 that is based on the prior year's financials. The plan includes SDOH-E priorities, partner information, proposed budgets and other information required by contract. OHA reviews CCO spending plans for compliance with contract requirements within 30 days. CCOs then have three years to spend down SHARE designations. Each June, CCOs report on actual SHARE expenditures for the prior calendar year in Exhibit L Report 6.71. It is expected that SHARE actual spending reflects planned spending. The information provided in this report was compiled from 2021 and 2022 CCO SHARE spending plans (referred to as *designated spending* or *designations* in this report).

Highlights of summary and analysis

Fifteen of 16 CCOs submitted SHARE spending plans in 2022. The approximately $26 million in designations reflect a five-fold increase in designated SHARE Initiative spending from 2021. CCOs plan to support 73 distinct SDOH-E partners this year, compared with 45 in 2021. At least half of those partners will be using the SHARE

Initiative funding to support projects focused on Oregon’s statewide priority of housing. Other project topics included SDOH-E partner organizational capacity building, physical infrastructure improvements, food and behavioral health. CCO spending was well aligned with community health improvement plans (CHPs), but there was considerable variability in the extent of CAC engagement in SHARE Initiative planning and decision-making.

Background and introduction

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

It is important to note that the SHARE Initiative is just one way CCOs may respond to SDOH-E, health inequities and the social needs of their members and communities. Examples of CCO community spending outside of SHARE can be found in these CCO SDOH-E spending reports.

The SHARE Initiative is part of a larger trend to direct federal dollars in support of SDOH-E efforts. The Center for Health Care Strategies has identified at least four other states (Arizona, California, Ohio, Pennsylvania) that have similar Medicaid community reinvestment requirements, though they are structured slightly differently. Medicaid payers in these states are required to reinvest 3–6 percent of their net income or profits in their communities (1). Oregon will require reinvestment on a sliding scale of 0–20 percent of adjusted net income starting in 2023 (see formula section of SHARE guidance). For the first two years, CCOs that met the minimum financial requirements chose how much to contribute to SHARE. CCOs may also reinvest more than the formula-based minimum.

The primary goals of the SHARE Initiative are to:

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

The SHARE Initiative is defined by state law and Oregon Administrative Rule, which requires that a CCO's SHARE Initiative dollars must meet the following minimum requirements:

1. Align with community priorities in the CCO's current community health improvement plan (CHP);
2. Include a role for the CCO's community advisory council (CAC);
3. Involve community partnerships, with a portion of dollars going to SDOH-E partners (see definition below); and

4. Fit into one of four SHARE Initiative domains related to SDOH-E: economic stability, neighborhood and built environment, education, and social and community health.

Due to a statewide housing crisis and feedback from partners, the Oregon Health Policy Board identified housing-related services and supports as a statewide priority of SHARE Initiative spending. As a result, a portion of SHARE spending must also be dedicated to housing.

Starting in 2023, CCOs are subject to a formula that determines their required minimum SHARE obligation based on their prior year financial reporting. As such, the spending plans summarized in this report reflect the final year of CCOs' voluntary SHARE contributions before the formula is applied.

SDOH-E partner:
A single organization, local government, one or more of the nine federally recognized Tribes of Oregon, the Urban Indian Health Program or a collaborative, that delivers social determinants of health and health equity (SDOH-E) related services or programs, or supports policy and systems change or both, within a CCO's service area (OAR 410-141-3735).

These program requirements are informed by the Oregon Medicaid Advisory Committee definition of and recommendations on social determinants of health as well as the Oregon Health Policy Board's policy recommendations. Guidance and definitions can be found in the 2023 CCO contract, OAR 410-141-3735 and on OHA's SHARE Initiative webpage.

SHARE Initiative spending plan summary and analysis

Spending amounts

Fifteen of 16 CCOs dedicated some of their 2021 profits to SHARE. For 11 of 16 CCOs, this was required due to annual net income or reserves that were higher than their financial requirements; however, four CCOs made SHARE investments that were not required. As noted above, the amount of SHARE spending for each CCO was not prescribed in 2022.

The total 2022 SHARE spending amount designated by CCOs was $26,185,457. This represents a more than five-fold increase over 2021 SHARE designated spending ($4,859,184). Amounts designated by individual CCOs ranged from $48,578 to $19,855,000. See Table 1 below.

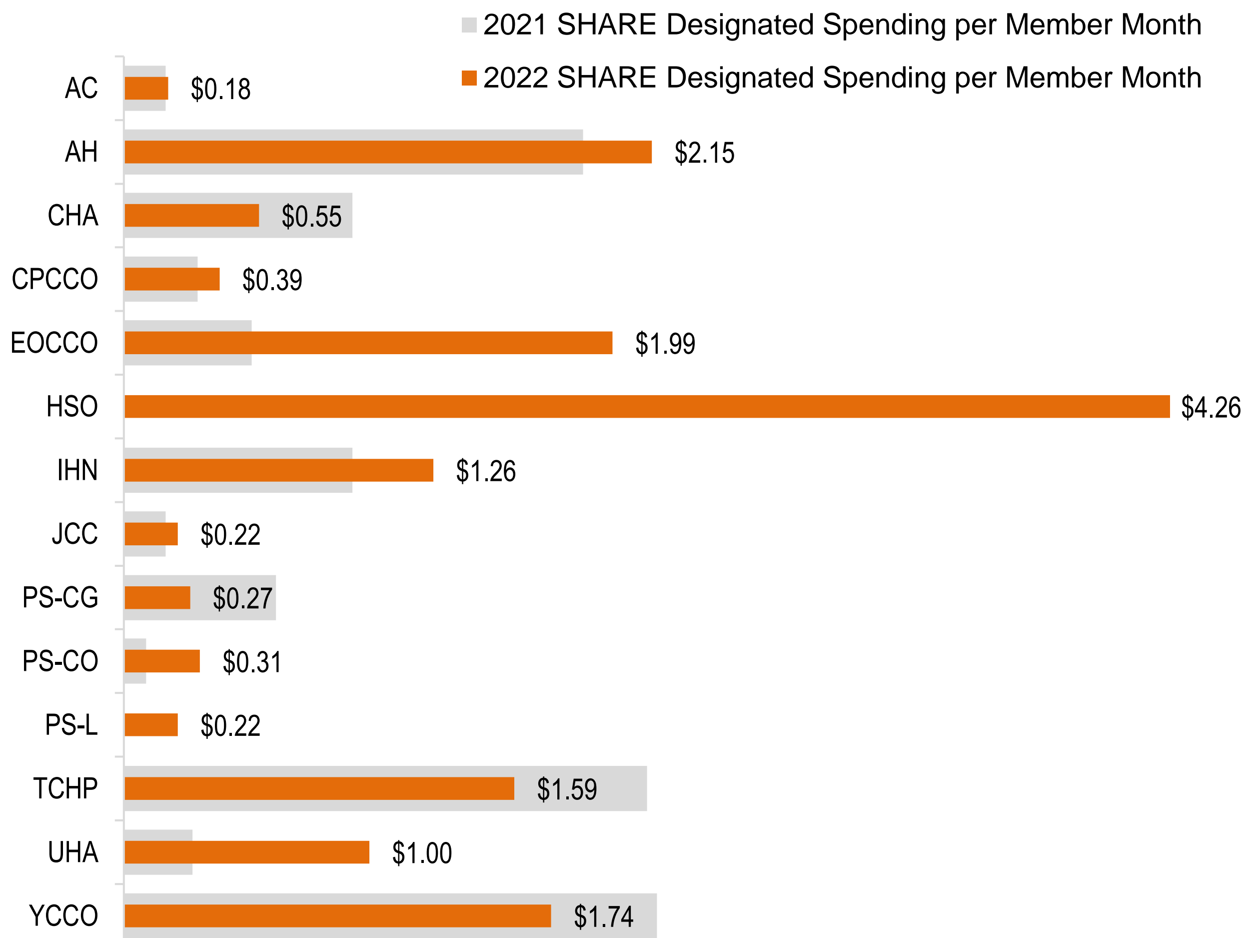
Overall, the average spending designated by CCOs for 2022 was $1.15 per member month, as compared with $0.85 per member month for 2021. See Figure 1 below.

Table 1. Overall SHARE designations*

SHARE designation year	2021	2022
Number of CCOs participating in SHARE	13	15
Total SHARE designations (all CCOs)	$4,062,545	$26,885,457
Smallest CCO designation amount	$57,992	$48,578
Largest CCO designation amount	$750,000	$19,855,000
Average designation amount per member month	$0.85	$1.15

*Note: This chart includes designations for each year, not actual spending. CCOs have three years to spend each year's designation.

Figure 1. Total CCO SHARE Designations Per Member Month (PMM)*,†



*Since 2020 member months were only available for Trillium-North (TCHP-N) and Trillium-Southwest (TCHP-SW) combined, numbers in the figure above were reported for the two CCOs together.
†HSO and PS-L were not required to designate SHARE spending in 2021.

Figure 1 above compares 2021 and 2022 SHARE designations per member month (PMM) by CCO. See Appendix A for CCO abbreviations. A member month refers to the total number of months Oregon Health Plan members were enrolled in a CCO's Medicaid plan. Due to the large variation of total member enrollment across CCOs, and that many members within a CCO are not continuously enrolled, member months were used to calculate SHARE spending in a consistent, comparable way across CCOs. Since SHARE plans are based on the CCOs' prior year financials, 2020 and 2021 member months were used to calculate designations for 2021 and 2022 plans, respectively.

Of the 15 CCOs that submitted SHARE spending plans, 10 increased their SHARE designations from 2021 to 2022. Four CCOs decreased their SHARE designations, and one CCO kept their SHARE designation constant. See Table 2 below for a comparison of 2021 and 2022 SHARE designations by CCO. Note that SHARE amounts are not reflective of all SDOH-E spending for any particular CCO. CCOs often make community investments outside of SHARE that are not reflected here.

Table 2. SHARE designations by CCO; change 2021 to 2022 in dollars ($) and percent (%)

CCO	2021	2022	Change ($)	Change (%)
Advanced Health (AH)	$500,000	$650,000	$150,000	30%
AllCare CCO (AC)	$100,000	$100,000	$ -	0%
Cascade Health Alliance (CHA)	$225,000	$150,000	$(75,000)	-33%
Columbia Pacific Coordinated Care Organization (CPCCO)	$100,000	$150,000	$50,000	50%
Eastern Oregon Coordinated Care Organization (EOCCO)	$342,229	$1,500,000	$1,157,771	338%

Health Share of Oregon (HSO)	$ - *	$19,855,000	$19,855,000	100%
InterCommunity Health Network (IHN)	$689,019	$1,076,144	$387,125	56%
Jackson Care Connect (JCC)	$100,000	$150,000	$50,000	50%
PacificSource-Columbia Gorge (PS-CG)	$98,305	$ 48,578*	$(49,727)	-51%
PacificSource-Central Oregon (PS-CO)	$57,992	$238,843*	$180,851	312%
PacificSource-Lane (PS-L)	$ - *	$ 200,500*	$200,500	100%
Trillium Community Health Plan-North (TCHP-N)	$441,217	$502,400*	$61,183	14%
Trillium Community Health Plan-Southwest (TCHP-SW)	$558,783	$500,000	$(58,783)	-11%
Umpqua Health Alliance (UHA)	$100,000	$400,000	$300,000	300%
Yamhill Community Care (YCCO)	$750,000	$ 663,992	$(86,008)	-11%

*SHARE designation not required.

Had the minimum SHARE spending formula been in place in 2022, total CCO designations would have been 3.1% (approximately $3.3 million) higher than actual designations. However, seven CCOs designated **more** than would have been required with the formula and eight CCOs designated **less** than would have been required. The formula goes into effect in 2023.

SDOH-E partnerships

Through the SHARE Initiative, CCOs are required to form cross-sector partnerships with community organizations and invest a portion of SHARE dollars directly in SDOH-E partners.

Across 2022 SHARE spending plans, CCOs reported 73 SDOH-E partnerships with a variety of organizations. The majority of SDOH-E partners were community-based nonprofit organizations, but other partners included local government agencies, behavioral health providers and federally recognized Tribes of Oregon. From 2021 to 2022 the total number of SHARE SDOH-E partners increased by 28 (62 percent). The number of partners by individual CCOs ranged from one to sixteen partners. The smallest investment in a SDOH-E partner was $3,500, and the largest was $7,600,000.

See Figure 2 for the number of SDOH-E partners by CCO and Table 3 for a comparison of SDOH-E partners by year.

Figure 2. Number of reported SHARE SDOH-E partners by CCO (2022)

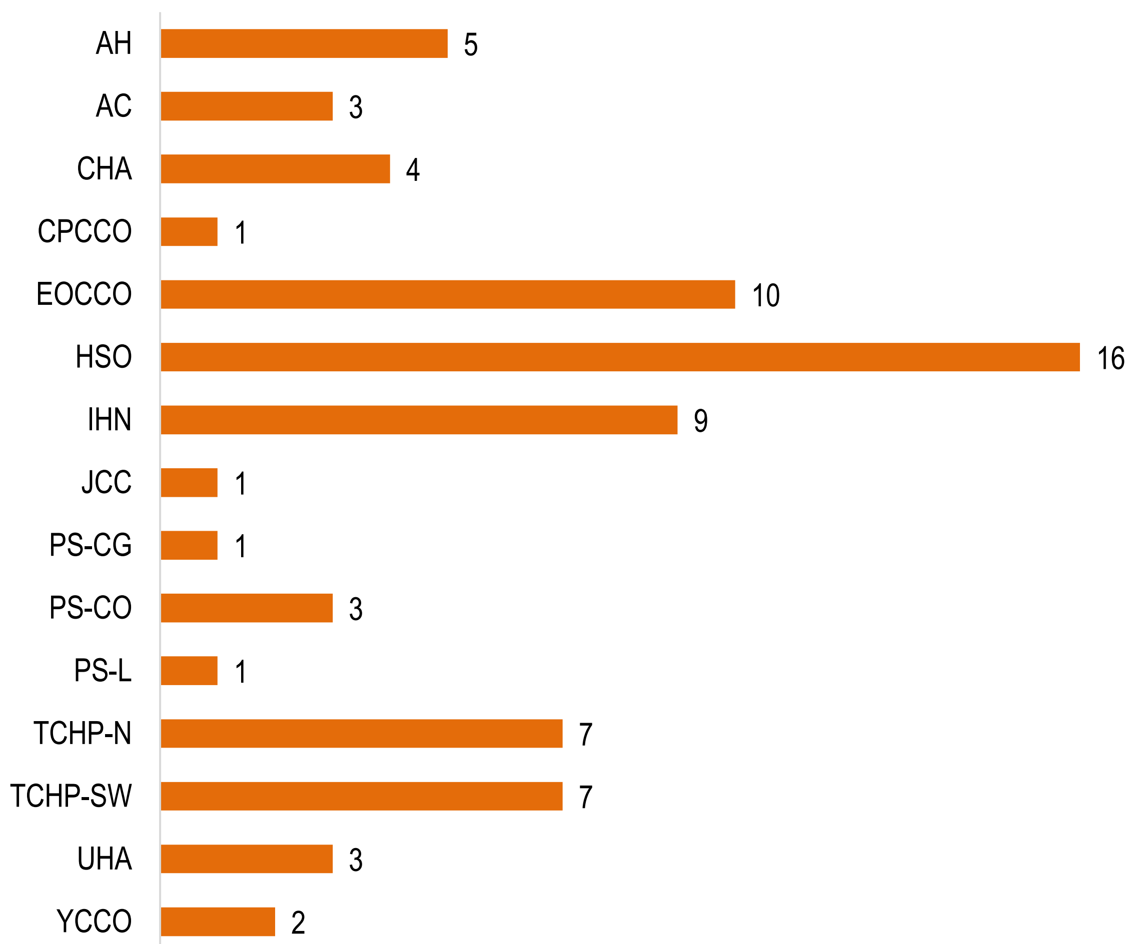


Table 3. Reported SHARE SDOH-E partners by year

SHARE designation year	2021	2022
Total SDOH-E partners for all CCOs	45	73
Smallest SDOH-E partner award	$600	$3,500
Largest SDOH-E partner award	$435,192	$7,600,000

SDOH-E partner selection

CCOs used a variety of approaches to identify and select SDOH-E partners. Five CCOs used open, competitive requests for proposals (RFPs) and two CCOs used an invited RFP application process. All other CCOs had staff or the governing board select projects based on input from the CAC, CHP priorities and/or prioritization of specific populations experiencing health inequities. At least 17 SDOH-E partners received continued funding based on a successful prior year SHARE project. See Appendix B for more detail and a list of 2022 SHARE SDOH-E partners.

Some innovative and notable approaches to selecting partners included:

- Selecting SDOH-E partners using an equity-focused screening tool
- Convening community partners to create an RFP process
- Soliciting input on housing spending from local housing coalitions

SDOH-E partner agreements

CCOs are required to enter into a written agreement (for example, contract or memorandum of understanding) with each SDOH-E partner that includes specific components. These agreements are included in spending plan submission and are posted publicly as part of the approved SHARE spending plan.

Overall, 54 percent of partner agreements were finalized at the time of spending plan submission. Five CCOs included all SDOH-E partner agreements with their SHARE spending plans, and ten CCOs finalized partner agreements for final plan approval after initial submission. Some of the stated reasons why CCOs did not initially submit finalized partner agreements include:

- Funding recipients not yet identified
- Delays identifying partners
- Delays finalizing agreements
- CCOs' aim to reduce administrative burden on SHARE partners, especially around the end of the calendar year
- Competing demands at the end of the calendar year

In addition, CCOs may want SHARE plan approval from OHA before finalizing partner agreements.

SDOH-E domains

SHARE Initiative spending must meet OHA's definition of SDOH-E (see box below), address at least one of four SDOH-E domains (economic stability, neighborhood and built environment, education, social and community health), and include spending towards the statewide housing priority of housing-related services and supports. For more information about what qualifies, see the OHA SHARE Guidance.

Social determinants of health and equity (SDOH-E)
OHA's definition of SDOH-E, available in OAR 410-141-3735, encompasses three interrelated terms:

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

In 2022, 72 percent of SHARE designations addressed more than one of the SDOH-E domains. See Table 4 below to see the number of projects addressing each SDOH-E domain.

Table 4. SHARE designations by SDOH-E domain*

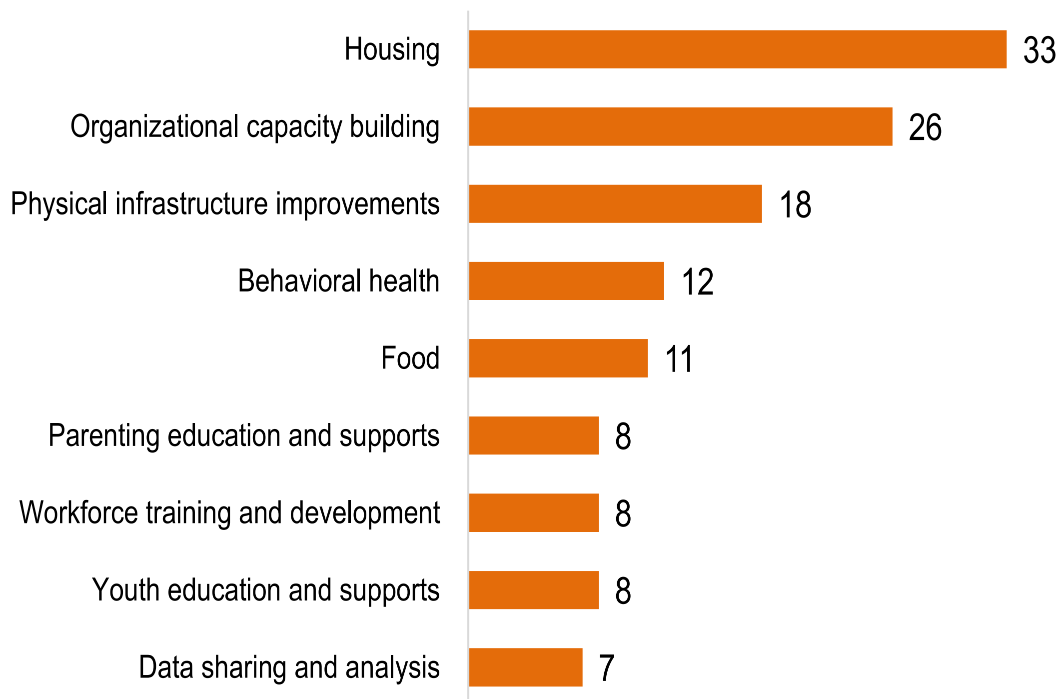
SDOH-E domain	Number of projects (out of 68 total)
Economic stability	43
Neighborhood and built environment	36
Education	17
Social and community health	46

*Note: SHARE Initiative projects can fall within multiple domains.

SHARE projects

Although 64 percent of SHARE projects included multiple topics, the most common were housing, capacity building for community organizations and physical infrastructure improvements. See Figure 3 for SHARE projects by category and Table 5 for category descriptions and examples. For a full list of SHARE project descriptions, including the SDOH-E partner lead(s) and supporting CCO, see Appendix B.

Figure 3. 2022 SHARE designations by project type*



*Note: Projects can fall into multiple categories.

Table 5. SHARE designation category descriptions and examples

Category	Description, examples
Housing	Funding toward any housing-related effort. Examples include: housing supports and services, capital costs, renovations, shelter and emergency stays, etc. See below for further detail into housing-related designations.
Organizational capacity building	Funds to build organizational capacity. Examples include: staffing or administrative costs to sustain or expand services; organizational or interagency strategic planning.

Physical infrastructure improvements	Funds to improve community infrastructure (excluding housing construction). Examples include: renovations of parks or playgrounds to encourage physical activity; construction of community kitchens or ADA accessible bathrooms; renovations of community centers or fire departments; purchase of equipment for SDOH-E partners to continue or expand services, such as computers.
Behavioral health	Funding to support the behavioral health (BH) sector, excluding Medicaid covered services. Examples include: infrastructure; online educational activities; support for organizations providing social-emotional health resources and SUD recovery.
Food	Funding to food-related efforts. Examples include: expansion of produce access programs; nutrition education classes and cooking demonstrations; emergency food assistance and congregate meals.
Parenting education and supports	Funding to provide education and support to parents. Examples include: parenting classes or workshops; parenting support groups; childcare.
Workforce training and development	Funds to provide staff training or professional development to improve equity or connections to SDOH-E supports. Examples include: culturally specific outreach to recruit staff; traditional health worker training; continuing education for interpreters; assistance obtaining doula certifications or licensures; expansion of culturally specific behavioral health workforce support groups.
Youth education and supports	Funding to provide education and support to children or youth. Examples include: early learning hubs or kindergarten readiness programs; indoor/outdoor play centers; youth behavioral health support programs.
Data sharing and analysis	Funding to launch data sharing platforms or evaluate health data. Examples include: implementing data sharing or community information exchanges; conducting project or data evaluations.

Housing-related SHARE projects

About half (33) of all 2022 SHARE projects were housing-related. See Appendix C for housing-related projects by CCO. To better understand the diverse range of housing projects described by CCOs, ORPRN conducted qualitative analysis and identified five main subcategories of **housing project type**. These subcategories include: 1) housing

services and supports, 2) permanent supportive housing, 3) transitional housing, 4) emergency shelters and 5) affordable housing. CCO housing projects were further grouped by the **activities being funded**. The funding categories that emerged were: 1) renovations or remodels, 2) capital expenses (for property acquisition, new construction or equipment), 3) organizational capacity building (for example, staffing) and 4) data or evaluation-related activities. Definitions and examples of these five housing project types and four spending categories are shared in Table 6 below.

Table 6. Descriptions and examples of housing-related project types

Housing project type	Description, examples
Housing services and supports	Services and supports that help people find and maintain stable and safe housing. Examples include: housing system navigation; establishing housing connections and referrals; assistance in rental or housing applications; independent living courses; home ownership training.
Permanent supportive housing	Permanent housing in which housing assistance (for example, rent assistance) and/or supportive services are provided. Examples include: scattered-site supported housing units, permanent supportive housing for individuals with substance use disorder or mental health concerns.
Transitional housing	Housing for individuals in transition between houselessness and permanent housing, usually limited to 90 days or less. Examples include: creation of transitional housing units, rent support for individuals in transitional housing units.
Affordable housing	Housing that costs no more than 30 percent of tenants' gross household income for rent and utilities. Examples include: building or renovating affordable housing units or homes.
Emergency shelters	Temporary housing accommodations for individuals who are houseless or at risk of becoming houseless. Examples include: low-barrier shelters; shelters for youth; hotel stays; warming and cooling shelters.
Other	Housing projects not specified or described above. Examples include: storage and equipment for unspecified types of housing; housing construction materials; generalized housing-focused projects.

Type of funded activities	Description, examples
Capital expenses	Funds to cover all or a portion of expenses to construct new housing. Examples include: architectural or building plans for new housing, construction costs to build single-family affordable homes; property acquisition of land or land trusts for transitional housing units, housing construction equipment.
Renovations, remodels	Funds to improve current housing facilities or transform current buildings into housing. Examples include: renovation of hotels into transitional housing units; home repairs and remediation.
Organizational capacity building	Funds to build capacity of housing supports, organizations or projects, including general operation or expansion costs. Examples include: staffing of housing support centers; multi-organizational strategic planning; operating costs.
Data or evaluation	Funds related to data sharing or evaluation for the purpose of connecting individuals to housing. Examples include: developing data sharing platforms to help connect unhoused individuals with resources; evaluating current community information exchange platforms; analyzing health outcomes of individuals served by housing programs.

Table 7 below depicts the types of housing addressed through CCOs' housing-related SHARE projects. The majority of these projects focused on housing services and supports, followed by emergency shelters. Funding was mostly allocated toward organizational capacity building for organizations delivering the services and supports, or capital expenses for creating new permanent, transitional or emergency housing.

Table 7. Housing project type by CCO*

	Housing services and supports	Permanent supportive housing	Transitional housing	Affordable housing	Emergency shelter	Other
AH	✔	✔	✔		✔	
AC			✔	✔		
CHA						
CPCCO	✔					
EOCCO	✔		✔	✔	✔	
HSO	✔		✔		✔	
IHN	✔		✔		✔	✔
JCC					✔	
PS-CG	✔				✔	
PS-CO						✔
PS-L	✔					
TCHP-N	✔					
TCHP-SW	✔	✔			✔	
UHA	✔		✔		✔	
YCCO		✔				
Total number of housing projects of this type*	23	5	10	2	14	3

*Projects can include multiple housing types.

Table 8. Housing activities being funded by CCO*

	Capital expenses	Renovations or remodels	Data or evaluation	Organizational capacity building
AH	✔	✔		✔
AC	✔			✔
CHA				
CPCCO		✔	✔	
EOCCO	✔	✔		✔
HSO	✔	✔	✔	✔
IHN			✔	✔
JCC		✔		
PS-CG				✔
PS-CO	✔			
PS-L				✔
TCHP-N				✔
TCHP-SW	✔			✔
UHA	✔	✔		
YCCO	✔			
Total number of projects funding this type of activity*	12	9	4	18

*Projects can include more than one kind of funding activity.

Populations served through SHARE projects

CCOs reported on a variety of populations that will be served through 2022 SHARE projects. The most prevalent population reported included people with health-related

social needs, which includes people who are housing or food insecure or who have lower incomes. Other populations frequently addressed included pregnant people, children and youth, and people of color and communities of color. Many of the 2022 SHARE projects reported serving multiple populations. Table 9 below details the amount of SHARE projects that reported serving specific populations.

Table 9. Populations addressed in 2022 SHARE designations*

Population	SHARE projects reported serving this population
People with health-related social needs, including people experiencing homelessness, unstable housing, or housing insecurity; people facing food insecurity; or with lower incomes	43
Pregnant people, children and youth	15
People of color, communities of color, including Black/African American, Latinx/o/a	10
People experiencing behavioral health concerns	7
Federally recognized Tribes of Oregon	5
People identified as having a disability, including people living with HIV	5

*Note: SHARE Initiative projects can address multiple populations.

Additional populations served included: LGBTQIA2S+ community; immigrants and refugees; farmworkers; women; survivors of intimate partner violence; people seeking language interpretation services; and people impacted by natural disasters.

SHARE alignment with community health improvement plans (CHPs)

CHPs are plans to improve health that are reflective of community priorities. CCOs are required to collaborate with local organizational partners to develop a CHP at least every five years. SHARE alignment with CHPs is just one way to ensure that strategic community investments are coordinated across partners and responsive to community needs. CCOs stated that all SHARE projects were aligned with at least one priority from the supporting CCO's CHP. Some projects were aligned with several CHP strategies or priorities. Table 10 below shows the most common CHP priorities to which CCOs aligned their SHARE plans. Not surprisingly, there were similarities in CHP priorities across CCOs.

Table 10. SHARE alignment with CCO CHP priorities

CHP Priority	Number of CCOs aligning SHARE with this CHP priority
Housing (Houselessness, stable housing, housing supports)	10
Behavioral Health (Behavioral health, trauma and resiliency, mental health, social connection)	9
Food Access (Food and nutrition, food insecurity)	7
Access to care	5
Economic stability, economic wellness	3
Family and parenting supports (Parenting supports, life skills, early childhood)	3
Physical health (Physical health, chronic conditions)	3
Health equity (Systems transformation, racial equity)	3
SDOH-E	2
Transportation	1

Community advisory council (CAC) role in SHARE

The SHARE Initiative requires each CCO's CAC to have a role in SHARE spending decisions. However, specific CAC engagement strategies for SHARE are not defined, so there is considerable variability across CCOs in the extent and depth of engagement with CACs in SHARE.

CCOs described at least five common approaches to engaging CACs in their SHARE spending plans, including the following (percentages are out of 15 CCOs):

- The CAC was consulted for feedback (87 percent).
- The CAC determined the SHARE priority areas (53 percent).
- The CAC made final project funding decisions and/or recommendations to the CCO board (53 percent).
- The CCO described a plan for engaging the CAC in ongoing monitoring of SHARE (53 percent).

- The CAC created/approved the overall SHARE decision-making process (13 percent).

All CCOs used at least one of these approaches, and many CCOs used several in their SHARE decision-making strategy. One CCO engaged their CAC through all five approaches. Table 11 displays the variety of approaches of CAC involvement.

Table 11. CAC involvement by CCO

	CAC was consulted for feedback on SHARE plans	CAC determined SHARE priority areas	CAC made final SHARE project funding decisions	Plan for CAC in ongoing monitoring of SHARE	CAC created or approved the overall SHARE decision-making process
AH	✓		✓		
AC	✓	✓			
CHA	✓			✓	
CPCCO	✓	✓		✓	✓
EOCCO	✓		✓	✓	
HSO	✓		✓		
IHN	✓	✓	✓	✓	✓
JCC		✓		✓	
PS-CG	✓				
PS-CO	✓	✓		✓	
PS-L	✓		✓		
TCHP-N	✓	✓	✓		
TCHP-SW	✓	✓	✓		
UHA				✓	
YCCO	✓	✓	✓	✓	

SHARE spending plan highlights and opportunities

Changes in spending amounts

In the second year of the SHARE Initiative, CCOs as a whole greatly increased both the amount of spending (five-fold increase) and the number and diversity of projects with SDOH-E partners (two-fold increase). If the formula were in place for 2022, total CCO SHARE investments would need to be 3.1% higher overall, yet at least seven CCOs made 2022 SHARE designations that exceeded the amount required were the formula already in place.

Partnerships and sustainability

Several CCOs continued funding prior year SDOH-E partners based on an evaluation that demonstrated a successful first project year. These sustained projects demonstrate deepening relationships between CCOs and organizational partners. These types of relationships, facilitated in part by the SHARE Initiative, are growing the infrastructure for future Medicaid systems that are inclusive of community organizations.

Housing as a SHARE priority

Housing remains a priority for SHARE in 2023. In January 2023, OHA issued new SHARE guidance that clarified that housing-related SHARE spending should focus on supports, services and permanent housing options. While the majority of CCO housing spending provides some form of housing services and supports, only a handful of CCOs designated spending for permanent supportive housing projects. Many CCOs are investing in emergency shelter projects and/or transitional housing. Over time, as emergency needs are met and local CCO/housing partnerships grow, CCOs can start to focus more on permanent housing solutions. A few CCOs leveraged existing best practice models like Project FUSE and Project Turnkey, an excellent way to expand the reach and impact of successful programs while also minimizing administrative burden on CCOs for standing up new initiatives.

Community engagement in SHARE

All CCOs seemed to easily align their SHARE spending plans with CHPs, as CHPs often include broadly defined, common social needs like housing or behavioral health. However, CAC involvement with SHARE spending decisions and plans, another indicator of whether SHARE spending is aligned with community priorities, varied across CCOs. While most CCOs asked CACs for feedback on SHARE plans, only about half of CCOs created a role for the CAC in decision-making about projects. This is

a good step toward centering health equity in programs and allowing community voice and need to direct funding decisions.

Like much community engagement, these CAC engagement approaches fall on a spectrum ranging from CAC consultation to empowered CAC decision-making. Strategies such as asking the CAC to create the overall decision-making process promote authentic and meaningful engagement with CACs. For example, one CCO co-created best practices for committee engagement with the CAC to increase standardization, transparency and equity. As federal and state requirements evolve toward greater community engagement in decision-making overall, CCOs can utilize a framework like the IAP2's Spectrum of Public Participation to increase the level of participation and ownership of CACs in SHARE spending decisions. Plans to further engage CACs in SHARE decisions should take into account the volume of work required of CACs through various Medicaid initiatives. CACs often report feeling overburdened and uncompensated.

Formal SDOH-E partner agreements

Getting SDOH-E partner agreements finalized at the time of spending plan submission continues to be a challenge for CCOs. In some cases, CCOs stated concerns about the administrative burden on partners. CCOs were challenged with coordinating a multi-step community engagement process prior to selecting and finalizing a partner agreement. Often CCO committees that provide input on the SHARE process meet monthly or less, creating a compressed timeline between availability of CCO financial information from the prior year, CAC engagement, SDOH-E partner selection and onboarding. Despite these challenges, getting SDOH-E partner agreements finalized prior to spending plan submission is crucial to build trust and formalize funding agreements with community partners. Timely partner agreements are also important to the success of the SHARE Initiative, as the agreements include information about line-item expenses, timelines, project objectives and milestones for success that contribute to measurement and evaluation for both CCOs and OHA.

Alignment across programs

Several CCOs are implementing forward-thinking strategies to connect various Medicaid-related initiatives through the SHARE Initiative. Some examples of this include defining the role for community information exchange platforms in housing services provision or investing in data infrastructure. Another innovative approach that builds the foundation for future efforts to integrate HRS, SHARE and the new health-related social needs (HRSN) benefit is an investment in an anchor organization (or hub) for other community organizations with an interest in increasing their capacity for Medicaid billing. CCOs that are thinking strategically about using the SHARE Initiative as one piece of a

larger effort to improve community health will be well prepared for implementing new initiatives as federal Medicaid partners continue to recognize and elevate the role of social factors in overall health.

Recommendations for next steps

After reviewing SHARE plans and conducting the analysis for this report, ORPRN compiled recommendations for both OHA and CCOs for future SHARE work.

Recommendations for OHA:

- Continue to update SHARE guidance to clarify statewide priorities and requirements.
- Adapt templates to reduce CCO reporting burden and improve evaluation opportunities.
- Continue to provide technical assistance for CCOs for SHARE plan development and innovation.
- Provide frequent and clear communication and guidance to CCOs about the planning and implementation of the Medicaid-covered benefits under the transitions program of the new 1115 Medicaid waiver as it relates to SHARE.

Recommendations for CCOs:

- Allow ample time for finalizing agreements with SDOH-E partners.
- Within the housing priority area, begin to shift from more short-term solutions (for example, emergency/transitional) to more long-term solutions like permanent supportive housing, leveraging successful models (for example, Project Turnkey) where possible.
- Over time, shift the CAC's role in decision-making about SHARE spending to become more collaborative than consultative.
- Allow ample time to scale up programs to anticipate larger spending amounts in 2023.
- Ensure 2023 spending plans account for changes in Medicaid-covered benefits under the transitions program of the new 1115 waiver starting in 2024 (as covered benefits expand, those activities will be no longer eligible under SHARE).
- Monitor the SHARE projects to ensure the priority populations identified are beneficiaries of the projects as intended.
- Look for opportunities to use SHARE to align multiple Medicaid SDOH-E flexibilities through innovative means (for example, supporting SDOH-E partner capacity building for all programs).

REFERENCES

1. Center for Healthcare Strategies and Association for Community Affiliated Plans (2023). Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review. Accessed at: https://www.chcs.org/media/Financing-Approaches-to-Address-Health-Related-Social-Needs-via-Medicaid-Managed-Care.docx.pdf

Appendix A: Coordinated care organization abbreviations

Coordinated care organization (CCO)	Abbreviation
Advanced Health	AH
AllCare CCO	AC
Cascade Health Alliance	CHA
Columbia Pacific Coordinated Care Organization	CPCCO
Eastern Oregon Coordinated Care Organization	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource-Columbia Gorge	PS-CG
PacificSource-Central Oregon	PS-CO
PacificSource-Lane	PS-L
PacificSource-Marion-Polk	PS-MP
Trillium Community Health Plan-North	TCHP-N
Trillium Community Health Plan-Southwest	TCHP-SW
Umpqua Health Alliance	UHA
Yamhill Community Care	YCCO

Appendix B. SHARE project summaries by CCO

CCO	SDOH-E partner	Amount ($)	Summary of work
AC	AllCare Community Foundation*	$25,000	Site planning and architecture for small, affordable cottages with innovative, cost-effective methods of building such as fire-safe technologies
AC	Brookings CORE Response	$25,000	Capacity building of Brookings CORE Response to offer safe and supportive transitional housing
AC	Rogue Food Unites	$50,000	Capital costs to build a commercial kitchen that will be used to provide shelf stable healthy meals and community meals
AH	Gold Beach Community Center*	$21,600	Nutritious congregate meals and nutrition education
AH	Kathy R Ingram, PhD Inc.	$52,000	Evaluation of AH's SHARE projects
AH	Coos Head Food Coop*	$86,400	Community outreach and nutrition education; implementation of a Farm to School program; doubled value of SNAP vouchers for healthy produce; partnership with school garden programs and local farms to address inequities among youth and families
AH	Oasis Advocacy and Shelter	$90,000	Funds to advance Project Turnkey; provide emergency and temporary housing assistance
AH	Coastal Families Relief Nursery	$110,000	Support to develop a diverse and representative board of directors, attain state certification as a relief nursery and retain qualified staff
AH	Nancy Devereux Center*	$290,000	Continued operation of the pallet home community; capital acquisition of a second scattered-site supported housing unit
CHA	Healthy Klamath*	$19,500	Purchase and install signs and maps
CHA	Klamath Works, Inc	$36,900	Relocation and build of a new community garden

CHA	Klamath Grown	$41,698	Staffing, education and harvest boxes provided to rural members and Tribes for 16 weeks
CHA	Tater Tots Pediatric Therapy	$51,902	Support to organization that serves children with disabilities to provide parent education, support groups, clubs, camps, supportive equipment
CPCCO	Community Action Team*	$150,000	Repairs, remediation measures and/or enhancements to improve home environments; Healthy Homes assessments and care coordination through Connect Oregon
EOCCO	Dayville Fire Department	$22,017	Upgrade and replace the Dayville Fire Department's fire and safety equipment
EOCCO	Take Root Parenting Connection	$30,000	Travel, operating and staffing costs for parent-centered workshops and group series
EOCCO	Oregon State University	$34,800	Provide food kits, cookware and utensils, advertising and travel costs for cooking demonstrations at four locations three times per year
EOCCO	Northeast Oregon Network on behalf of Housing Matters Union County*	$56,000	Funds for staffing, travel costs, renovations, rent and utility assistance, and legal and consulting fees to establish a long-term warming station, support a resource center, establish a land trust, provide homeownership training, develop two single-family permanent affordable housing sites and support two families to own land trust
EOCCO	Northeast Oregon Compassion Center	$107,583	Administrative and staffing costs; computers for telehealth and education; vocational and educational materials; childcare
EOCCO	Eastern Oregon University Head Start	$249,600	Construction of age-inclusive playgrounds at a low-income housing complex and two Head Start sites; ADA accessible bathrooms, social-emotional engagement plan, kitchen remodel and purchase of a vehicle at a Head Start location

EOCCO	Community Counseling Solutions	$250,000	Renovation of a transitional living house; weekly assistance in grocery shopping, education management and service referrals
EOCCO	Eastern Oregon Center for Independent Living*	$250,000	Renovation of a building into low-barrier housing with supports and services for up to 26 EOCCO members living with HIV
EOCCO	Pendleton Children's Center	$250,000	Construction of a new childcare and early learning hub, indoor play area, ADA accessible restrooms, kitchen and breakroom
EOCCO	Grant County Cybermill	$250,000	Construction of a CyberMill location to improve access to non-covered tele-behavioral health services and online educational activities with a free computer lab
HSO	Multnomah County	$400,000	Expansion of Help me Grow program for American Indian and Alaska Native families: staffing, parenting education, community outreach and training
HSO	Oregon Doula Association	$500,000	Doula workforce development: training and assistance obtaining state certification to support culturally and linguistically diverse communities, campaign and resources to increase service use
HSO	Oregon Health Care Interpreters Association	$525,000	Training, assistance obtaining certification and continuing education for interpreters for selected languages and communities, workforce needs assessment
HSO	Oregon Health Leadership Council; 211info	$41,000; $509,000	Contribution to a statewide evaluation of Connect Oregon; support for staffing the 211Info Coordination Center
HSO	Rockwood Community Development Corporation of Oregon	$1,000,000	Renovation costs for 75 units of non-congregate transitional housing; renovations for a multi-service center with ten community-based organizations providing housing supports and services

HSO	Oregon Public Health Institute	$1,500,000	Creation and implementation of an equitable grantmaking process (Oregon Public Health Institute); capacity building and operational support for culturally specific food community-based organizations
HSO	Corporation for Supportive Housing	$2,000,000	Capacity building for community-based organizations (CBOs) to offer Medicaid benefits; central convener (Corporation for Supportive Housing) to support other CBOs on billing, tracking, workflows, community information exchanges and training traditional health workers
HSO	Adelante Mujeres; Immigrant & Refugee Community Organization; Clackamas County; Oregon Pediatric Improvement Partnership; Portland State University System of Care	$425,510; $562,286; $40,000; $147,400; $824,804	Capacity building for culturally specific and inclusive community-based organizations providing social-emotional health resources for young children and their families; workforce development and training, culturally specific education and messaging, service provision infrastructure
HSO	Multnomah County	$3,780,000	Start-up and operating costs for the Behavioral Health Resource Center; mental health shelter and bridge to housing programs
HSO	Washington County	$7,600,000	Capital costs for acquisition and renovation of the Center for Addictions Treatment and Triage to provide social services, sobering services, peer services and supportive housing
IHN	Cascade West Council of Governments	$45,796	Interagency strategic planning to assist unhoused and housing insecure in accessing resources through community information exchange, referral loops and gaps analysis

IHN	Samaritan Health Services*	$65,033	Analysis of health data for patients served by a housing program; summarization of how health status and needs differ among subpopulations of people experiencing houselessness
IHN	Reconnections Alcohol & Drug Treatment, Inc.	$66,000	Rent of three motel rooms; substance use support and navigation services by traditional health worker and peer support specialists
IHN	Lincoln County	$82,875	Development of an independent living curriculum (Basic Life Skills trainings, educational opportunities, service coordination) for youth at a homeless shelter
IHN	Corvallis Daytime Drop-in Center	$104,440	Housing-related supports and services: life stabilization training, Coordinated Entry, housing direct connections and referrals
IHN	Unity Shelter	$110,000	Capacity building through staffing of coordination and navigation support persons for emergency and transitional housing
IHN	Family Assistance and Resource Center Group*	$126,000	Respite and emergency housing with wraparound services; expansion of client intake
IHN	Oregon State University Foundation, InterCommunity Health Research Institute	$226,000	Support strategic planning through evaluation of pilot projects and dissemination of key findings to improve population health and health equity
IHN	Northwest Oregon Works	$250,000	Behavioral health workforce development: culturally specific recruitment and training
JCC	Oasis Center of the Rogue Valley	$150,000	Creation of an emergency shelter for at-risk pregnant people on the waitlist for residential substance use disorder treatment; renovation of three apartments adjacent to primary care clinic
PS-CG	Mid-Columbia Community Action	$48,578	Funding for a full-time shelter manager/lead resource navigator and two part-time shelter staff at the Hood

	Council*		River Winter Shelter
PS-CO	Warm Springs Housing Authority	$72,228	Construction of a storage facility for equipment, lumber and construction materials for building and repairing homes
PS-CO	Confederated Tribes of Warms Springs Reservation of Oregon	$80,250	Renovation of a community skatepark; helmets and pads for community youth
PS-CO	Simnasho Firehall	$86,365	Renovation and critical repairs to the Simnasho Firehall to restore operations
PS-L	Daisy CHAIN	$200,500	Culturally specific pregnancy, birth and postpartum education; care coordination, referrals and direct supports; workforce development of certified bilingual doulas and certified lactation consultants
TCHP-N	The Immigrant and Refugee Community Organization	$3,500	Wheelchair ramp for the Immigrant & Refugee Community Organization's bazaar
TCHP-N	Latino Network	$25,000	Funds to a capital campaign to support a community health worker community center
TCHP-N	All: Ready Regional Kindergarten Readiness Network	$55,000	Kindergarten readiness program for communities of color
TCHP-N	Quest Integrative Health	$84,324	Transitional housing for African American, LGBTQIA+, HIV positive clients; case manager for housing support services; group meetings
TCHP-N	Raices de Bienstar	$84,324	Grow a support network for Latino/Latina/Latinx traditional health workers
TCHP-N	Harmony Academy	$84,324	Outreach and programming for youth and communities impacted by substance use disorder

TCHP-N	Rockwood Community Development Corporation	$165,928	Support food pantry and delivery program; fund one community health worker to provide housing services and outreach
TCHP-SW	Food for Lane County*	$60,000	Expand Produce Plus program to new sites serving people of color and LGBTQIA+ clients; implement new food screening tool
TCHP-SW	Carry It Forward	$60,000	Mobile shower unit, ADA shelter unit, kitchen unit, laundry unit; partial coverage for a personal health navigator
TCHP-SW	Burrito Brigade	$60,000	Emergency food assistance
TCHP-SW	CORE	$60,000	Staffing, renovation, transition and furnishing for new advocacy center to serve at-risk youth; launch Advocacy Center's life skills training program
TCHP-SW	Square One Villages	$60,000	Contribution to capital costs of a land trust and limited equity co-op for the Peace Village Co-op permanent affordable housing
TCHP-SW	Eugene YMCA	$100,000	Help fund the construction of the new Lane County YMCA pediatric room
TCHP-SW	FUSE Program Lane County*	$100,000	Connect houseless frequent users of services to supportive services and housing
UHA	Umpqua Heart	$100,000	Develop and operationalize homeless village and low barrier shelter in Sutherlin; provide services and supports
UHA	ADAPT	$100,000	Remodel and develop a recently acquired hotel into SUD transitional housing; provide supports and services
UHA	City of Roseburg*	$200,000	Develop and operationalize low barrier shelter in Roseburg
YCCO	Yamhill County Health and Human Services*	$163,992	Continued construction of 37 new units of permanent supportive housing for individuals with a history of drug use and/or mental illness

YCCO	Housing Authority of Yamhill County	$500,000	Contribution to construction of 175 units of permanent affordable housing that will have services and supports onsite

*SDOH-E partner supported with both 2021 and 2022 SHARE plans

Appendix C: Housing-related projects by CCO

CCO	Number of housing-related SHARE projects	Amount of housing-related SHARE designations ($)*
AC	2	$50,000
AH	2	$380,000
CHA	-	-
CPCCO	1	$150,000
EOCCO	3	$556,000
HSO	4	$12,930,000
IHN	7	$600,144
JCC	1	$150,000
PS-CG	1	$48,578
PS-CO	1	$72,228
PS-L	1	$200,500
TCHP-N	2	$250,252
TCHP-SW	3	$220,000
UHA	3	$400,000
YCCO	2	$663,992

*Housing-related SHARE projects are defined in Tables 7 and 8; Housing-related SHARE designations may include non-housing aspects.

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