2023 SHARE Initiative Guidance for CCOs

January 4, 2023

Supporting Health for All through REinvestment: the SHARE Initiative

Contents

This document will provide guidance to help CCOs:

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

Background and overview

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. SHARE Initiative spending is legislatively **required**, is in CCO contract, applies to those CCOs that exceed financial requirements[1] and is spent from excess end-of-year profits. The SHARE Initiative began in 2020.

The primary goals of the SHARE Initiative are to:

- Safeguard public dollars by requiring that a portion of CCOs' profits[1] are reinvested in their communities; and
- Improve CCO member and community health by requiring reinvestments go toward upstream non-healthcare factors that impact health (for example, housing, food, transportation, educational attainment or civic engagement).

[1] House Bill 4018 refers to "annual net income or reserves of the CCO that exceed the financial requirements specified in this paragraph...." This document uses the term "profits" as a shorthand equivalent to encompass the statutory terms.

The SHARE Initiative includes the following program requirements:

Requirement 1: Spending must fall within social determinants of health and equity (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 their community advisory councils (CACs) related to SHARE Initiative spending decisions.

These program requirements are informed by the Oregon Medicaid Advisory Committee (MAC) definition of and recommendations on social determinants of health as well as the Oregon Health Policy Board's CCO 2.0 policy recommendations. Additional guidance and definitions can be found in the 2023 CCO contract, OAR 410-141-3735 and on OHA's SHARE Initiative webpage.[i]

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.

SHARE requirement 1: SDOH-E domains and housing priority

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; and
- 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 adopted a definition of social determinants of health and health equity (SDOH-E),[ii] which is available in OAR 410-141-3735. The SDOH-E definition encompasses three interrelated terms as defined below.

- ✓ **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.

See Appendix A for more SHARE-related definitions.

Four SDOH-E domains for SHARE Initiative spending and examples

In addition to meeting the general definitions above, SHARE Initiative spending must target at least one of four domains of SDOH-E as prioritized by the MAC:[iii]

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

The following table includes 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.

Note: Strategies targeted exclusively at health care or access to health care are not included in these SDOH-E domains for eligible SHARE spending, as these are part of a CCO's foundational work in Oregon's health care system. Dollars from the SHARE Initiative are meant to address needs beyond the "clinic walls" through community partnerships.

SDOH-E domain	Project ideas	Examples of prior SHARE projects
Economic stability	• Income/poverty • Employment • Food security/insecurity • Diaper security/insecurity • Access to quality childcare • Housing stability/instability (including houselessness) • Access to banking/credit	• Expand transitional shelter to create space for clients to complete job and housing applications, and provide technology access at the shelter • Fund education and training for childcare teachers of children of domestic violence survivors • Purchase mobile shower and laundry facilities • Purchase a multi-unit residence to create transitional housing
Neighborhood and built environment	• 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	• Convene a local collaborative to increase access to healthy food • Provide nutritious meals for homebound seniors and in congregate settings • Implement Veggie Rx programs • Purchase accessible playground equipment • Create a permanent, affordable housing community for low income and unsheltered residents • Implement oral health campaign to promote increased fruit/vegetable or decreased sugar-sweetened beverage consumption
Education	• Early childhood education and development • Language and literacy • High school graduation	• Fund intergenerational youth enrichment activities • Fund site planning and construction of a new schoolyard

	• Enrollment in higher education	• 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 • Support school districts to fund skills trainers and behavioral interventionists
Social and community health	• 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)	• Fund FTE or training for traditional health worker and peer wellness support for social service navigation • Fund community-based organizations for start-up, staffing and training costs associated with a social needs screening and referral system through a community information exchange
All domains	• 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	

See more project examples to meet the housing priority in the next section.

Statewide priority: Housing-related services and supports

Due to a statewide housing crisis and feedback during the CCO 2.0 policy engagement period, the Oregon Health Policy Board identified housing-related services and supports as a statewide priority 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. OHA is also supporting a statewide effort to increase permanent supportive housing (see definition on next page). CCOs are encouraged to explore ways to use SDOH-E spending for these initiatives, in collaboration with their community and CAC, to invest in the most effective and robust interventions possible.

SHARE dollars come from a CCO's net profits or reserves and are not considered in the medical loss ratio or rate development. Because of this, SHARE projects have the flexibility to fund room and board as long as it's not a covered benefit (see next paragraph) for the population being served.

SHARE dollars may **not** be spent on the housing-related supports that are covered benefits for specific populations under Oregon's 1115 Medicaid waiver (beginning in 2024) or Substance Use Disorder 1115 waiver.

Examples of projects addressing the housing requirement are in the table below.

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 available but are not mandated as a condition of obtaining tenancy. See Appendix A for full definition.

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

Housing priority	Individual-level project examples	Community-level project examples
Housing-related supports and services Note: Projects to meet the housing-related supports and services requirement must also fall into one or more of the four SDOH-E domains above.	• Housing navigation services for behavioral health clients • Healthy homes improvements for members experiencing health inequities and accessibility issues • Rental assistance	• Partner with local housing organizations and/or community-based organizations to combat discrimination in housing communities • Purchase a multi-unit residence to create transitional housing • Create a permanent, affordable housing community for low income and unsheltered residents • Create a land trust to purchase land ready for development • Create, convene and fund a regional housing coalition

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.

CCOs have been required to develop CHPs since 2012. More recently, the CCO contract and OAR 410-141-3730 require CHPs to be shared with local public health authorities, hospitals, other CCOs and any of the nine federally recognized Tribes of Oregon in the CCO's service area. OHA developed CCO Guidance: Community Health Assessments and Community Health Improvement Plans to help CCOs meet this 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 spending should align with the CCO's most recent CHP at the time of SHARE spending plan submission.

SHARE requirement 3: SDOH-E partners

CCO's 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 nine federally recognized Tribes of Oregon, 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 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, community-based organizations and local health departments). Here are some examples of potential 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)
- Culturally specific organizations
- Local public health authorities
- Regional health equity coalitions
- Local government and government-associated entities
- Oregon Tribes and the Urban Indian Health Program
- Educational services districts and school districts
- Early learning hubs
- Local housing authorities

The CCO must enter into a written agreement (for example, contract or memorandum of understanding) with each SDOH-E partner that defines minimum requirements listed below. If the written agreement is a subcontract as defined in the CCO contract, then it must also satisfy all requirements in Exhibit B, Part 4, Section 11 of the CCO contract. The CCO must include the Subcontractor and Delegated Work Report, updated for any subcontracts with SDOH-E partners, with its SHARE Initiative Spending Plan.

Note: 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.

The CCO shall ensure 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 (for example, CCO members, community members, Tribal communities, communities of color, etc.);
- How outcomes will be measured and evaluated, including:
    - Specific, measurable, achievable, relevant, time-based, inclusive and equitable (SMARTIE) objectives (see SMARTIE resources); and
    - How outcomes align with community priorities from the CCO's community health improvement plan (CHP); and
- 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 consumer 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 of the CCO contract and OAR 410-141-3735:

- The CCO is responsible for providing a role for its CAC in SHARE Initiative spending decisions.

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 align with community priorities in the CHP.

- The CAC reviews SHARE Initiative 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.

For CAC resources, visit the CAC supports webpage.

SHARE minimum spending formula and obligation

Starting in 2023, CCOs will be subject to a formula that determines their required minimum SHARE obligation based on their 2022 financial reporting. CCOs will follow the instructions in the Exhibit L6.7 financial reporting template to apply this formula to their 2022 financials and report their 2023 SHARE designation. CCOs will describe how their designation will be spent in their 2023 spending plan. This requirement will be reflected in rule changes to OAR 410-141-3735, effective January 1, 2023.

If a CCO does not exceed minimum financial reserve requirements[iv], they are presumed exempt from the SHARE Initiative. CCOs have three years to spend down each year's SHARE designation. CCOs have the option to request a one-year extension (four years total).

The 2023 SHARE obligation shall equal or exceed the greater of:

- **A percentage of average adjusted net income** for the prior three calendar years on a sliding scale based on the CCO's risk-based capital (RBC) percentage at the end of 2022 (but prior to the SHARE portion calculation):
    - 0% of adjusted net income at or below 300% RBC, grading up to 20% of adjusted net income at or above 500% RBC; or
- **10% of dividends** recorded or similar payments or both to shareholders, **including adjusted net income earned by capitated affiliates**
    - Capitated affiliates' adjusted net income is calculated with respect to the capitated affiliates' lines of business under the CCO as reported to OHA through the CCO's financial statements under OAR 410-141-5015.
    - Dividends or similar payments solely designated to satisfy tax obligations of affiliates that arise on account of serving the CCO's Oregon Health Plan members shall be excluded, provided that the CCO provides documentation approved by OHA.

The formula and specifications are reflected in the 2022 Exhibit L template published to OHA's CCO Contract Forms page. See OAR 410-141-3735 for additional details on application of the formula and its defined terms.

CCOs are expected to honor their financial commitment (designation) to community partners. If any changes to SHARE designation amounts are needed, CCOs should consider the impact of a funding change for community partners and notify OHA of any changes via the process outlined in the "Changing SHARE designations" memo to CCOs (9/9/22).

Spending exclusions for the SHARE Initiative

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

- Medicaid-covered services[2] (a CCO may not count expenses that are factored into its global budget);
- Any covered services or benefits in Oregon's Substance Use Disorder (SUD) waiver (housing or employment supports for eligible members) or 1115 Medicaid waiver (health-related social needs services for eligible members, beginning in 2024).
- Any activities, projects or initiatives targeted exclusively at delivery of health care or expanding access to care;
- Expenses that have been reported separately, such as health-related services (HRS) or in lieu of services (ILOS) — CCOs may not double-count spending;
- 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; or
- Advocacy specific to CCO operations and financing (as opposed to advocacy for policy that advances SDOH-E objectives).

See Appendix B for a checklist to help determine whether a project is eligible for SHARE spending. CCOs are encouraged to contact OHA at Transformation.Center@odhsoha.oregon.gov with questions about allowed and disallowed uses of SHARE dollars prior to developing their spending plans.

[2] Medicaid-covered services do not qualify as SHARE Initiative spending, as they are already reported through existing financial reporting mechanisms. While certain Medicaid-covered services address an individual's social needs (for example, some behavioral health populations may be eligible for certain housing-supportive services through Medicaid), these services are not eligible for SHARE spending.

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 and Appendix C: SHARE Timeline. The Exhibit L reporting templates identified below are provided on the CCO Contract Forms webpage. The SHARE Initiative templates are provided on the SHARE Initiative webpage. CCOs are required to use the OHA-provided spending plan and spending report templates.

CCO deliverable	Description	Next due
SHARE Initiative Spend-Down Report Exhibit L, Report 6.71	Annual report of year-over-year spend-down of SHARE funds.	**June 30**; reporting on 2022 spending
SHARE Initiative Detailed Spending Report (Required template)	Annual report of detailed SHARE spending for the prior calendar year, using the template provided	**June 30**; reporting on 2022 spending
2023 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, including: 1) annual risk-based capital prior to SHARE contribution; 2) annual pre-tax net income prior to SHARE contribution; and 3) dividends recorded.	**June 30**; based on 2022 financials
2023 SHARE Initiative Spending Plan (Required template)	Annual plan includes SDOH-E priorities, partner information, proposed budgets and other information as required by contract, using the template provided.	**December 31**[3], for CCOs with a 2023 SHARE designation

References

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

[ii] 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

[iii] 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

[iv] 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

[3] **CCOs may submit their spending plans at any time from 4/1 through 12/31**. OHA will notify each CCO about the approval status of its plan within 30 days of receipt. If a CCO's plan cannot be approved as submitted, OHA will work with the CCO to resolve the identified deficiencies as quickly as possible.

Appendix A: Definitions

Health equity: 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.

Source: CCO contract, Exhibit A

Health-related social needs (social needs): An individual's social and economic barriers to health, such as housing instability or food insecurity.
Source: OAR 410-141-3735

Permanent supportive housing: Permanent supportive housing 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 houseless or at risk of becoming houseless and people who are institutionalized or at risk of institutionalization. Permanent supportive housing generally refers to a specific building or site dedicated to providing deeply affordable housing paired with housing supports.
Source: Oregon's Statewide Housing Plan (2019-2023)

SDOH-E partner: A single organization, local government, one or more 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.
Source: OAR 410-141-3735

SHARE designation: The amount of funding a CCO chooses and reports as a contribution for SHARE initiative spending; designation amount must be at least the minimum SHARE obligation.

SHARE designation year: The year in which the CCO reports the SHARE designation amount to OHA (based on previous year's financials).

SHARE obligation: The amount of funding a CCO is required to contribute to the SHARE Initiative based on audited financials and the statutory required formula.

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.

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.
Source: OAR 410-141-3735

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.
Source: OAR 410-141-3735

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 is scattered site housing. To be considered supported housing, for buildings with two or three units, no more than one unit may be used to provide supported housing for people with serious and persistent mental illness (SPMI) who are referred by OHA or it contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for people with SPMI who are referred by OHA or it contractors. 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.
Source: CCO contract, Exhibit A

Appendix B: SHARE Initiative project eligibility checklist

To be eligible for SHARE spending, projects or activities must meet the following criteria. More details are available in the SHARE Initiative guidance document. If you have additional questions, please email Transformation.Center@odhsoha.oregon.gov

- ☐ The project addresses at least one domain of **social determinants of health and equity**: economic stability, neighborhood and built environment, education or social and community health. See the guidance document for examples of each of the domains.
- ☐ The project will fund **non-clinical, upstream activities** – that is, it is not focused on health, health care or accessing health care (which are part of a CCO's foundational work in Oregon's health care system).
- ☐ The project is **not funding Medicaid-covered benefits** or the delivery of Medicaid-covered benefits. This includes the recently expanded covered benefits in Oregon's Substance Use Disorder (SUD) waiver (housing or employment supports for eligible members) or 1115 Medicaid waiver (health-related social needs services for eligible members, beginning in 2024).
- ☐ The project is **not funding equipment or services to address an identified medical need**.
- ☐ Project activities are **not being submitted as health-related services (HRS)** or otherwise being double-counted as other expenses.
- ☐ The project **aligns with the CCO's community health improvement plan** priorities.
- ☐ The project **addresses the statewide priority of housing-related supports and services**. If it does not address housing-related supports and services, the CCO's SHARE spending plan must include at least one other project that does.
- ☐ The CCO's **community advisory council has a role** in selecting or approving the projects within the spending plan.
- ☐ The project **dollars are going to an SDOH-E partner**. If not, the CCO's SHARE spending plan includes other projects with funds going to one or more SDOH-E partners.
- ☐ The project activities are **not general administrative costs** that are otherwise necessary for the regular business operations of the CCO.
- ☐ The project is **not funding member incentives** (for example, gift cards for accessing preventive services).
- ☐ The project is **not funding educational or promotional items or goods for general distribution** through a health fair or other event not targeted at populations experiencing health disparities.
- ☐ The project is **not funding political campaign contributions.**
- ☐ The project is **not funding advocacy specific to CCO operations and financing.**
- ☐ The project is **not funding SDOH-E related research** in which findings are only used internally, only used by another private entity, or are proprietary.

Appendix C: Timeline of SHARE Initiative planning, reporting and spending