oscar

# ARHOME Strategic Plan

## Summary

Oscar's ARHOME Strategic Plan outlines the scope, structure and objectives of the programs and activities that Oscar intends to deploy in plan year 2022 to promote the goals and objectives of the ARHOME program.

## Introduction

The overarching goal of Oscar's ARHOME Strategic Plan (ARHSP) is to promote the goals and objectives of the ARHOME program by:

1) Understanding members' health and utilization profiles,
2) Designing, implementing, and evaluating activities and interventions to improve members' health and experience,
3) Designing, implementing, and evaluating activities and interventions that support the DHS Health Improvement Initiative and Economic Independence Initiative.

This document outlines Oscar's strategy, including how Oscar conducts regular assessments of the population, segments and stratifies the population for interventions, refines and develops new population health programs, and integrates data from numerous sources. Oscar's strategy is based on best practices for Population Health Management established by the National Committee for Quality Assurance.

## Population Assessment

To create new population health and incentive-based programs, in addition to modifying existing ones, Oscar uses a systematic process to identify the needs of its member population. Oscar's Population Health and utilization dashboards, annual health risk assessment, and social determinants of health assessments are used to evaluate whether adjustments are necessary to better address the needs of Oscar's enrolled population in multiple domains, including:

- Evaluation of sociodemographic characteristics and needs[1] — including an impact analysis of relevant social determinants of health, such as subsidy status, primary language, and racial/ethnic group.
- Evaluation of behavioral risk factors — such as smoking, alcohol consumption, physical activity.
- Evaluation of health status and risks, using utilization data categorized by multiple age cohorts[2] based on the enrolled product lines. Children and adolescents' needs are analyzed separately from adults.

[1] NCQA HPA 2021 Standards PHM.2B.1
[2] NCQA HPA 2021 Standards PHM.2B.3

- Evaluation of health conditions — such as the needs of members with multiple chronic conditions, disabilities[3] and/or severe and persistent mental illness (SPMI)[4].

This annual analysis along with ongoing review of the data provides insight into changes in the health or utilization status of the population and relevant clinical segments[5] that could warrant consideration for new programs, services, resources[6] and activities (or revisions to existing programs and services, including metrics, usability and community resources)[7]. Subsequent adjustments to population health management program design are implemented based on these findings. All of these tools are used to continuously improve existing programs.

Moreover, Oscar evaluates the extent and limitations of community resources[8], including an assessment of the member's eligibility for community resources that address member needs beyond the scope of the health plan. Oscar connects members with community resources and promotes community programs. These could include supplemental benefits and services, such as community mental health, wellness organizations, palliative care programs, transportation, nutritional support, and other national or community resources. Oscar goes beyond posting a list of resources on its website or mobile application by actively searching for and sharing pertinent community resources when a specific need is identified.[9]

## Population Stratification

To stratify its member population and determine program eligibility, Oscar integrates data from multiple sources (enumerated below), across care sites (e.g., inpatient, ambulatory) and across domains (e.g., clinical, business, operational):

1. Medical and behavioral claims or encounters[10]
2. Pharmacy claims[11]
3. Laboratory results[12]
4. Health appraisal results[13, 14]
5. Health services programs within the organization: utilization management, care management[15]
6. Advanced data sources: health information exchanges (HIEs)[16]

These data sources are integrated into Oscar's Clinical Segmentation model for multiple purposes. Oscar's clinical segmentation model is used to target programs, interventions, and services to its enrolled member population. The model runs daily, identifying and risk-stratifying enrolled members with similar phenotypic profiles of health status and

[3] NCQA HPA 2021 Standards PHM.2B.4
[4] NCQA HPA 2021 Standards PHM.2B.5
[5] NCQA HPA 2021 Standards PHM.2B.2
[6] NCQA HPA 2021 Standards PHM.2C.2
[7] NCQA HPA 2021 Standards PHM.2C.1
[8] NCQA HPA 2021 Standards PHM.2C.3
[9] NCQA HPA 2021 Standards PHM.2C.3
[10] NCQA HPA 2021 Standards PHM.2A.1
[11] NCQA HPA 2021 Standards PHM.2A.2
[12] NCQA HPA 2021 Standards PHM.2A.3
[13] NCQA HPA 2021 Standards PHM.2A.4
[14] Health appraisals are completed at least annually by members. Members' self-reported health status, exercise frequency, PHQ-2 score, drinking and tobacco use patterns, and BMI are utilized as contributing factors to a member's clinical segment.
[15] NCQA HPA 2021 Standards PHM.2A.6
[16] NCQA HPA 2021 Standards PHM.2A.7

complexity. Using a combination of various data sources and clinically-informed scoring logic, the model divides the population into seven segments reflecting clinical complexity. Members are sorted into different segments as data becomes available.

Using this data, Oscar can target programs, interventions, and services to the appropriate segment based on their complexity. For example, Oscar members with the highest degree of clinical complexity, who are sorted into the model's most complex clinical segments, are targeted for enrollment into suitable programs, such as Complex Case Management (CCM). Eligible members who are enrolled in CCM receive comprehensive, higher-touch interventions, with multiple components that address continuity of care, individualized goals, and relevant referrals to resources.

The model was built based on literature review and clinical reasoning and incorporates data from claims, health risk assessment (HRA) and labs/tests. All members are assigned to 1 of 7 mutually exclusive groups; members can transition between groups over time but can only exist in 1 group at any point in time. An eighth group exists, "Unknown" that captures members new to Oscar and who have not yet generated data sufficient for segmentation.

Table 2 describes the clinical segments and their definitions.

Table 2. Overview of Oscar's Clinical Segmentation Approach[17]

| Clinical Segment | Definition |
|---|---|
| Complex Outlier | Member with 2 or more conditions that are statistically unlikely to co-occur; Members are ranked and then a cutoff is applied to define the group |
| Chronic major complex | Member with 2 or more complex chronic conditions or 6 or more non-complex chronic conditions |
| Chronic minor complex | Member with one complex chronic condition and 0-5 non-complex chronic conditions |
| Chronic non-complex | Member with ≥ 1 non-complex chronic conditions |
| Acute condition | Member with an acute condition (e.g., ankle fracture) for which resolution of the condition with no long term sequelae is suspected |
| Risk factors | Member with risk factors for disease based on self-reported behavioral risk (smoking, high alcohol consumption, obesity) or laboratory data suggestive of elevated risk in the absence of confirmed disease |
| Healthy | Member who does not meet criteria for any of the other segments<br>Member may have active health issues, but that confer little risk<br>Member may have a history of health issues but these have since resolved |
| Unknown | In the first 2 months of enrollment, before claims have been received |

[17] NCQA HPA 2021 Standard PHM 2.D

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| | for new members, clinical segmentation cannot be determined and member is labeled "Unknown" |

A description of subsets and the types of interventions offered to Oscar's members is outlined in the ARHSP Programs and Services section below.

## ARHSP Clinical Programs and Services[18]

Oscar offers a number of programs and services for members identified as likely to benefit from additional support based on population stratification or other data inputs. Programs and activities are intended to promote improved health outcomes across a number of focus areas. Program performance and improvement opportunities are monitored via metrics that span a variety of categories, including engagement, utilization, clinical, quality and experience. The clinical programs and services that make up Oscar's ARHSP are outlined in Table 3. Oscar has a reward and incentive program that can be tailored and personalized to encourage members to be engaged in their health and well-being.

Table 3. Overview of Oscar's ARHSP Clinical Programs and Services

| Focus Area | Program Name | Eligible Population |
|---|---|---|
| Keeping members healthy | Preventive Services Promotion | Members identified as at risk for gaps in preventive services or condition-based best practices |
| Keeping members healthy | Cervical Cancer Screening Program | Women ages 21-64, based on USPSTF criteria, who do not meet HEDIS exclusion criteria (e.g., hysterectomy) |
| Keeping members healthy | Colorectal Cancer Screening Program | Adults ages 50-75, based on USPSTF criteria, who do not meet HEDIS exclusion criteria (e.g., history of colorectal cancer, total colectomy) |
| Managing members with emerging risk | HbA1c Testing Program | Adults ages 18-75, identified as having type 1 or type 2 diabetes |
| Managing members with emerging risk | Maternal Management Program | Members who are pregnant |
| Managing members with emerging risk | ER Diversion | Members identified as at risk of going to an emergency room through digital engagement |
| Patient safety or outcomes across settings | Post-Hospital Recovery | Members admitted for inpatient events at acute care hospitals for chronic conditions |
| Managing acute and chronic conditions; Managing members | Care Coordination | Members identified as having care gaps or in need of general care advocacy or condition support |

[18] NCQA HPA 2021 Standard PHM 1.A.2

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| with emerging risk | | |
| Managing acute and chronic conditions | Complex Case Management (CCM) | Members who have experienced a critical event or diagnosis, the degree and complexity of illness or condition is typically severe; members eligible for CCM may include those with physical or developmental disabilities, serious mental illness, multiple chronic conditions, or severe injuries |
| Managing acute and chronic conditions | Autoimmune Program | Members diagnosed with an Autoimmune condition taking biologic drug(s) |
| Managing acute and chronic conditions | Diabetes Program | Members diagnosed with Type 1 or Type 2 diabetes |
| Managing acute and chronic conditions | Behavioral Health Case Management | Members who require support for high risk mental health and substance use disorders |
| Managing acute and chronic conditions | NICU Management Program | Newborn members who require intensive care services. |

Below, Oscar provides a detailed summary of selected programs that align with each of the five focus areas: (1) keeping members healthy, (2) managing members with emerging risk, (3) assessing patient outcomes across settings, and (4) managing acute and chronic conditions, including managing mental health and substance use disorders.

| Preventive Services Promotion | |
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| Eligible population: | Members identified as at risk for gaps in preventive services or condition-based best practices |
| Focus area: | Keeping members healthy |
| Program goal(s): | The Preventive Services Promotion program is designed to promote health and well-being among Oscar members through member outreach and education relating to healthy behaviors and preventive services.<br><br>Performance targets for this program are based on state-based HEDIS benchmarks, or where appropriate, ARHOME baseline values.<br><br>We will initially concentrate on the following performance targets. Breast, Cervical and Colon cancer screening for eligible members will have a goal of achieving the 75th percentile of HEDIS. The goal for annual exam completion is based on Oscar's internal data. |
| Program services: | • Annual wellness visit promotion, including offering in home assessments or virtual visits for members unable to visit a PCP. Members who have an annual wellness visit with their PCP or complete an in home assessment will receive a $25 gift card.<br>• Alerting members to evidence-based preventive and |

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| | condition-based services they are eligible for on the member website and app - in addition, if eligible members create an online account, they will receive a $25 gift card.<br>● Multi-channel outbound educational campaigns promoting flu and COVID vaccination<br>● Multi-channel member outreach to promote medication adherence<br>● Outbound educational campaigns related to comprehensive diabetes care, breast and colon cancer screenings<br>● Reminders and structured educational campaigns about opportunities to optimize comprehensive diabetes care and cancer screenings when applicable members call into their care teams |
| Activities not directed at members: | Coordination of in home assessments or virtual visits with providers. |
| Methods and data sources used to identify the eligible population | Oscar assesses enrollment data and claims data (medical, laboratory, and pharmacy) to identify members who meet inclusion criteria for the various preventive and condition-based services promoted.<br><br>This program is segment agnostic. |

| Cervical Cancer Screening | |
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| Eligible population: | Women ages 21-64, based on USPSTF criteria, who do not meet HEDIS exclusion criteria (e.g., hysterectomy) |
| Focus area: | Keeping members healthy |
| Program goal(s): | Primary measure used to set program goals and evaluate performance: % of the eligible population that completes appropriate cervical cancer screening (*utilization measure*)<br><br>Performance targets for this measure based on ARHOME baseline values.<br><br>Our performance goal for this measure is the 75th percentile of HEDIS |
| Program services: | Email and mail reminders, outbound phone campaigns, engagement with our provider partners through aligned incentives. |
| Activities not directed at members: | Incremental measure feedback is shared with providers e.g., In home assessment vendor, Oscar Medical Group (virtual providers), and targeted network providers. Measure specific provider education has been created and shared. |
| Methods and data sources used to identify the eligible population | Oscar assesses enrollment data and claims data (medical, laboratory, and pharmacy) to identify members who meet inclusion criteria for preventative screening services. |

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| | This program is segment agnostic. |

| Colorectal Cancer Screening | |
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| Eligible population[19]: | Adults ages 45-75, based on USPSTF criteria, who do not meet HEDIS exclusion criteria (e.g., history of colorectal cancer, total colectomy) |
| Focus area: | Keeping members healthy |
| Program goal(s)[20]: | Primary measure used to set program goals and evaluate performance: % of eligible population that completes appropriate colorectal cancer screening *(clinical process measure)*<br><br>Performance targets for this measure based on state-based HEDIS benchmarks.<br><br>Our initial performance goal will be to achieve the HEDIS 75th percentile |
| Program services: | Email and mail reminders, outbound phone campaigns. In addition, we are able to send test kits directly to members to remove barriers to completing screening. |
| Activities not directed at members: | Incremental measure feedback is shared with providers e.g., In home assessment vendor, Oscar Medical Group (virtual providers), and targeted network providers. Measure specific provider education has been created and shared. |
| Methods and data sources used to identify the eligible population | Oscar assesses enrollment data and claims data (medical, laboratory, and pharmacy) to identify eligible members who meet inclusion criteria for preventative screening services.<br><br>This program is segment agnostic. |

| HbA1c Testing | |
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| Eligible population: | Adults ages 18-75, identified as having type 1 or type 2 diabetes |
| Focus area: | Managing members with emerging risk |
| Program goal(s): | Primary measure used to set program goals and evaluate performance: % of the eligible population that receives an A1c test (*clinical process measure*)<br><br>Performance targets for this measure based on state-based HEDIS benchmarks. |
| Program services: | Email and mail reminders, virtual care appointments, In Home Assessments and outbound phone campaigns |
| Activities not directed at members: | Incremental measure feedback is shared with providers e.g., In home assessment vendor, Oscar Medical Group (virtual providers), |

[19] NCQA HPA Standards 2021 PH.1A.1

[20] NCQA HPA Standards 2021 PH.1A.1

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| | and targeted network providers. Measure specific provider education has been created and shared. |
| Methods and data sources used to identify the eligible population | To identify the eligible population, Oscar integrates data from multiple sources across care sites (e.g., inpatient, ambulatory) and across domains (e.g., clinical, business, operational). These data sources include: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health services programs within the organization: utilization and care management, as well as advanced data sources, such as health information exchanges (HIEs). |

| Maternal Management Program | |
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| Eligible population: | Members who are pregnant |
| Focus area: | Managing members with emerging risk |
| Program goal(s): | Oscar's maternity program is currently in pilot phase, with goal of future scale. The program targets all members who are pregnant, inclusive of, but not specific to, high risk pregnancies.<br><br>The overall goal of the program is to improve maternal and child outcomes through:<br>1) Early identification of members who are pregnant<br>2) Engagement with members to support identification and routing to high quality maternity providers<br>3) Encouraging establishment of early, consistent and quality prenatal care<br>4) Promotion of clinical screening adherence<br>5) Building trust and offering clinical support<br><br>Key program metrics will include:<br>● Enrollment rates (engagement)<br>● C-section rates (clinical)<br>● NICU admission rates (clinical)<br>● Maternity and perinatal HEDIS metrics (quality)<br><br>Our goal for this population is to engage members so the timeliness of prenatal care HEDIS measure is above 70%. Those members engaged in this program will receive a $25 gift card. |
| Program services: | Care routing, pregnancy and postpartum educational content, education about maternity benefits, nurse case management and social worker escalation and support |
| Activities not directed at members: | Data sharing with provider partners to confirm network status and delivery facility status, vendor DME support (e.g., breast pumps), care coordination directly with providers |

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| Methods and data sources used to identify the eligible population | Oscar members are eligible for the Maternal Care Management program if they are pregnant. Pregnant members are identified via:<br>● Provider visit or lab claims<br>● Member self identification<br>● High risk pregnancies are identified via the program's onboarding survey and escalated to case management<br>Additionally, Oscar is studying the following indicators to identify eligible members earlier in their pregnancy to ensure members establish prenatal care promptly:<br>● Call and message data<br>● "Maternity" keyword searches<br>● Visiting Oscar's Maternity landing page<br>● Claims with pregnancy counseling codes |

| ER Diversion Program | |
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| Eligible population: | Members identified as at risk of going to an emergency room through digital engagement |
| Focus area: | Managing members with emerging risk |
| Program goal(s): | The specific goals of this program are to:<br>● Reduce avoidable member visits to the emergency room.<br>● Increase member usage of urgent care for lower acuity conditions.<br>● Route members to in network emergency rooms when condition acuity warrants emergent care. |
| Program services: | Real-time secure message outreach<br>Virtual urgent care appointment scheduling<br>Emergency room and urgent care routing<br>Partnering with providers to identify and reduce those members at risk for avoidable ER visits |
| Activities not directed at members: | N/A |
| Methods and data sources used to identify the eligible population | Oscar members identified as at risk for using the emergency room based on their interactions with Oscar (e.g., searching for care in the provider directory) are eligible for participation in the ER Diversion Program. Members using pertinent Oscar engagement tools are evaluated using a logistic regression to determine the likelihood that they might go to an ER in the next 3 days. The model uses:<br>● Care router (online provider directory) search history<br>● Concierge Team call notes<br>● Secure message text<br>● Monitored conditions database |

| Post-Hospital Recovery | |
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| Eligible population: | Members admitted for inpatient events at acute care hospitals for chronic conditions with the exception of:<br>● Members under 18 years of age<br>● Members who are pregnant or have recently delivered<br>● Members who have elective procedures |
| Focus area: | Patient safety or outcomes across settings |
| Program goal(s): | Primary measures and program goals are listed below. The overall purpose of the program is to reduce readmission rate for the eligible population by intervening with members after high-priority admissions to ensure recovery plan adherence. (*utilization measure, clinical outcomes)*<br><br>● PCP Follow-Up: 60% of members will follow-up with a PCP within 30 days post-discharge (Clinical process measure)<br><br>● Post-discharge ER Visit Rate: <30% of members visit the ER in the 30 days following discharge (Utilization)<br><br>● 30-day Readmission Rate: Minimize the percentage of members readmitted within 30 days of index hospitalization (among those with qualifying conditions/diagnoses). Performance targets for this measure is an all cause 30-day readmission rate of <11.7%.<br><br>● Member Experience: >70% of members agree or strongly agree across at least 3 out of 5 domains (Member Experience).<br>○ Ratings of member experience within Post-Hospital Recovery is based on information about the overall program, the program staff, usefulness of the information, members' ability to adhere to recommendations, and percentage of members indicating that the program helped them achieve health goals. |
| Program services: | Discharge planning, including supporting follow-up appointments and coordinating in-network post-acute services, such as home health and durable medical equipment (DME); SDoH needs; transfers to a post-acute facility; Case Managers work with members to ensure adequate transitional care; outpatient provider follow-up; medication regimen optimization and adherence; daily health self-evaluations |
| Activities not directed at members: | Case Managers engage facility staff (Inpatient, SNF, ARU, etc) to coordinate discharge needs for the member with the goal of |

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| | ensuring a safe transition from the facility and to remove any discharge barriers that exist. On occasion, Case Managers may also outreach members' providers or families to coordinate care. |
| Methods and data sources used to identify the eligible population | Oscar ingests and surfaces inpatient admission data from a variety of sources to Case Managers to initiate the post-hospital recovery process. These include: authorization requests, benefit and eligibility checks, and Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs) where available.<br><br>Additionally, Oscar establishes direct feeds with health system partners to capture real-time ADT data from the systems' electronic health records (EHRs) when able. |

| Care Coordination Program | |
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| Eligible population: | Members who need assistance navigating the healthcare system or managing an acute or chronic condition |
| Focus area: | Managing acute and chronic conditions; Managing members with emerging risk |
| Program goal(s): | ● Educate members about the benefits of case management and how to use available resources<br>● Help members understand their medical and/or mental health condition(s)<br>● Support and encourage self-management skills to promote and optimize the member's personal health and well-being goals<br>● Coordinate necessary medical and behavioral health care services<br>● Refer to appropriate medical or social community resources, when applicable<br><br>The above are intended to promote improved health-related outcomes, including increased preventive care, reduced ER and inpatient utilization, and improved care plan adherence. |
| Program services: | ● Inbound and outbound care routing support to find the most appropriate in-network PCPs and specialists for members' individual needs<br>● Health education related to members' conditions and health status<br>● Responding to Clinical Alerts related to ER visits, inpatient admissions, and disease-specific topics<br>● Escalating cases to Complex Case Management (CCM) when appropriate |
| Activities not directed at members: | Care coordination directly with PCPs, specialists and/or hospital case managers to coordinate appointments, DME, medication adherence issues, etc. |

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| Methods and data sources used to identify the eligible population | The primary mechanisms to identify members for participation in the Care Coordination program are:<br>1) referral via Oscar's Concierge Team members,<br>2) data-directed surfacing,<br>a) Claims data, health appraisal data, and laboratory/testing data<br>b) Clinical alerts from ADT or HIE feeds<br>3) medical management referral from utilization management (UM) team,<br>4) practitioner referrals,<br>5) member or caregiver referrals. |

| Complex Case Management (CCM) | |
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| Eligible population: | 1. Members are eligible for the CCM program if they meet one or more of the following criteria:<br>a. 3 or more ER or inpatient visits, year-to-date<br>b. Prolonged inpatient or post-acute stay (7 or more days inpatient, 14 or more days post-acute)<br>c. One or more high complexity procedures (e.g., transplant, heart valve procedure)<br>d. One or more high risk-conditions (e.g., cirrhosis, end-stage renal disease, gastroparesis)<br>e. Presence of high-risk comorbidity or factor (e.g., mental health, functional limitations, poor social support)<br>f. If more active Case Management would benefit the member due to potential high cost utilization<br>2. And if potential CCM interventions would be beneficial to the member. |
| Focus area: | Managing acute and chronic conditions |
| Program goal(s): | Enrollment into Oscar' CCM Program involves a comprehensive needs assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case-management plan with performance goals, monitoring, self-management plans, and follow-up[21] [22].<br>● 30-day Readmission Rate: <20% of members readmitted within 30 days of prior discharge (regardless if different diagnosis) (Utilization)<br>● Primary Provider Routing: % of members with a primary provider (PCP or specialist) visit within 3-months after CCM enrollment (Clinical process Measure) |

[21] NCQA HPA 2021 Standards PHM.5C
[22] NCQA HPA 2021 Standards PHM.5E

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| | ● Member Experience: >70% of members agree or strongly agree across at least 3 out of 5 domains (Member Experience).<br>○ Ratings of member experience within CCM is based on information about the overall program, the program staff, usefulness of the information, members' ability to adhere to recommendations, and percentage of members indicating that the program helped them achieve health goals. |
| Program services: | Authorization support; complex DME identification and procurement support; facility visits; home visits; routing to and coordination with PCP and specialists; ER avoidance; home evaluation and improvement services; needs assessments with care gap & SDoH barrier closure |
| Activities not directed at members: | Oscar collaborates with community-based organizations and hospitals to improve transitions of care from the acute and post-acute setting to the home. |
| Methods and data sources used to identify the eligible population | There are five primary mechanisms to identify members for participation in the CCM program:<br>6) referral via Oscar's Concierge Team Case Managers[23],<br>7) data-directed surfacing,<br>a) Claims data, health appraisal data, and laboratory/testing data<br>8) (medical management referral from utilization management (UM) team[24],<br>9) practitioner referrals[25],<br>10) member or caregiver referrals.[26] |

| Autoimmune Program | |
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| Eligible population: | Members with a diagnosed autoimmune condition taking specialty medication(s) for their condition. Eligible conditions include, but are not limited to:<br>● Multiple sclerosis<br>● Inflammatory bowel disease<br>● Rheumatoid Arthritis<br>● Psoriasis and/or Psoriatic arthritis<br>● Lupus |
| Focus area: | Managing acute and chronic conditions |
| Program goal(s): | Primary measures and program goals are listed below. Oscar utilizes a vendor (Mymee) for this program. Mymee is a digital therapeutic solution for members with chronic autoimmune |

[23] NCQA HPA 2021 Standards PHM.5A.2
[24] NCQA HPA 2021 Standards PHM.5A.1
[25] NCQA HPA 2021 Standards PHM.5A.4
[26] NCQA HPA 2021 Standards PHM.5A.3

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| | conditions. The overall purpose of the program is to identify dietary and environmental triggers of autoimmune disease to 1) reduce associated symptoms, 2) improve health-related quality of life (HRQoL), and 3) reduce need and usage of specialty medications where appropriate. *(utilization measure, clinical outcomes)*<br><br>● Medication Savings: 20% reduction in specialty medication spend among the participant group for 18 months following core program enrollment, vetted through claims data. (Utilization)<br><br>● HRQoL Improvement: 30% absolute improvement for 9 distinct HRQoL indicators rated worst at baseline tracked at 0, 4, 6, and 12 months from core program enrollment. (Clinical outcomes) |
| Program services: | Access to Mymee's 16-week personalized digital health program, including: one-on-one health coaching, digital app for data capture, symptom tracking to identify specific triggers |
| Activities not directed at members: | Incremental measure feedback for specialty medication reduction and HrQoL indicators is shared with Oscar throughout the program duration and up to 12 months following program completion. |
| Methods and data sources used to identify the eligible population | Oscar members are eligible for the Mymee program if claims data identifies them as being prescribed specialty medication for the treatment of diagnosed, eligible autoimmune condition(s). |

| Diabetes Management Program | |
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| Eligible population: | Members with type 1 or type 2 diabetes |
| Focus area: | Managing acute and chronic conditions |
| Program goal(s): | Oscar partners with Livongo for its Diabetes Management Program. Livongo offers members comprehensive and personalized diabetes monitoring and management support. All participants are provided with a free connected glucose monitor, which is used to engage and communicate with participants, as well as free test strips and lancets. Members are connected with certified diabetes educators for more hands-on clinical expertise and support as needed.<br><br>Key program metrics include:<br>● Engagement / enrollment rates (engagement)<br>● Hemoglobin A1c improvement (clinical)<br>● Diabetes-related ER and inpatient utilization (clinical)<br>● Diabetes-related HEDIS metrics (quality) |
| Program services: | Free glucometer, free testing strips and lancets, remote blood glucose monitoring, medication adherence monitoring, 1:1 |

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| | coaching and education with certified diabetes educators, meal plan |
| Activities not directed at members: | Data sharing and care coordination between Livongo and Oscar |
| Methods and data sources used to identify the eligible population | Oscar members are eligible to participate in the Diabetes Management Program if they have a diagnosis of type 1 or type 2 diabetes. Oscar shares claims data with Livongo for identification and outreach of members who are potentially eligible. |

| Behavioral Health Case Management Program | |
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| Eligible population: | 1. Members are eligible for the CM program if they meet one or more of the following criteria:<br>a. The member has been discharged from an inpatient admission.<br>b. Members considered high cost and/or high need, including members with repeated behavioral health inpatient admissions.<br>2. If potential CM interventions would be beneficial to the member. |
| Focus area: | Managing acute and chronic conditions |
| Program goal(s): | The Plan partners with a Managed Behavioral Health Organization, Optum, to provide support and case management for high risk members with mental health and substance use disorders. The Optum case management program includes a comprehensive assessment to identify needs, challenges, goals, and barriers to recovery, and provides ongoing support to monitor progress and help meet the identified goals.<br><br>Key program metrics include:<br>● Reach, enrollment and completion rates (engagement)<br>● Behavioral health-related HEDIS and NQF metrics (quality)<br><br>Oscar will initially focus on the following performance metrics with a goal of achieving the 75th percentile HEDIS benchmarks:<br>● Follow up after hospitalization for mental illness (7d): 55%<br>● Anti-Depression medication management: 68%<br>● Initiation and engagement of alcohol and other drug dependence treatment: 26% |
| Program services: | Needs assessment and care planning, connection to outpatient care and support, transitional care services, identification of need for and referral to community resources |
| Activities not directed at members: | Integrated medical-behavioral “rounds” between Oscar and Optum case managers to review admissions, discharges, transfers and general case notes; platform for shared data and information |

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| | between Oscar and Optum case managers; provider / facility outreach for transitional care planning |
| Methods and data sources used to identify the eligible population | There are five primary mechanisms to identify members for participation in the behavioral health case management program:<br>1) referral via Oscar's Concierge Team Case Managers,<br>2) data-directed surfacing, e.g., claims data<br>3) medical management referral from utilization management (UM) team,<br>4) practitioner referrals,<br>5) member or caregiver request. |

| NICU Management Program | |
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| Eligible population: | Newborns requiring intensive care |
| Focus area: | Managing acute and chronic conditions |
| Program goal(s): | Oscar partners with Progeny to provide the NICU Management Program to support parents and their newborn babies in need of intensive care.<br><br>Progeny's NICU and pediatric-trained teams have the expertise to manage an infant's care plan while providing resources, education and support to the families during the NICU stay and throughout their first year of life. Progeny's NICU-specialized utilization and care management teams monitor the newborn telephonically from the moment they enter the NICU through consistent interaction with the hospital care team. Progeny simultaneously connects with the family to provide support, education, medical coordination, and advocacy on their behalf. Progeny continues to provide services to families for up to 12 months after birth to support successful transitions home.<br><br>Key program metrics include:<br>● Engagement / enrollment rates (engagement)<br>● NICU length of stay (clinical)<br>● ER and readmission rates (clinical)<br>● Member satisfaction |
| Program services: | NICU authorization support; NICU Care Plan management; SDoH support; transitional care support; care coordination; parental support and education |
| Activities not directed at members: | Progeny works directly with the facility to facilitate a seamless and evidence-based NICU stay (authorizations, etc.), monitor the newborn's care plan, and support a smooth transition home upon discharge readiness. |

| | |
|---|---|
| Methods and data sources used to identify the eligible population | All newborns who require intensive care following birth are eligible for the NICU Management Program. Members are identified when a facility requests an authorization for a newborn requiring intensive care. This information is shared with Progeny for facility and family outreach. |

## Coordination of Member Programs[27]

Oscar utilizes its Concierge Model to engage members and optimize experience. Concierge Teams drive coordination with Oscar members across all ARHSP programs and activities.

- Upon enrollment, each Oscar member is assigned to a Concierge team based on their home address. Concierge Teams consist of Case Managers, Social Workers, and Care Guides. With Concierge, every time a member calls or secure messages into Oscar, they reach the same set of individuals who help coordinate personalized care, leveraging a complete picture of the member's health and history with Oscar.

- Case Managers directly drive many of the outbound ARHSP programs and activities and are available for any clinical questions from members on their geographic-based panel. Care Guides support all inbound member questions regarding plan benefits, bill pay, network, and others. Concierge teams are also supported by Network Navigators and Concierge Experts who support teams with expertise in Oscar's Network and Insurance Operations, respectively.

- Concierge teams coordinate most programs and activities directly (e.g., Case Managers drive Post-Hospital Recovery for members on their panels) and are notified of any outbound communication that they do not directly initiate (e.g., marketing mailers to all members including educational information on ER alternatives). This visibility allows Concierge teams to weave member engagement points into a cohesive conversation with the member and seamlessly avoid member confusion.

- Oscar's telemedicine service is similarly integrated with other Oscar programs. For example, Care Guides or Case Managers on Concierge Teams can connect members to Oscar's telemedicine service when requested. Data related to member's telemedicine calls is ingested into Oscar's core data infrastructure and is combined and leveraged with other utilization information about members.

## Informing Members about Available Programs and Services[28] [29]

Oscar recognizes it services a heterogeneous population, which requires a multi-channel approach to meet the communication preferences and needs of the varied members we

[27] NCQA HPA 2021 Standards PHM.1A.4
[28] NCQA HPA 2021 Standards PHM.1A.5
[29] NCQA HPA 2021 Standards PHM.1B.1-3

service. Based on this, Oscar uses multiple methods to inform members about their benefit plans and the various programs and services offered, including:

- Person-to-person
    - Inbound and outbound phone calls with our Concierge Teams
    - Other Oscar strategic outbound teams
    - Through our network providers (via provider communication channels)
- Traditional
    - Via mail
- Digital
    - Mobile and web application, including secure messaging
    - Website
    - Email
    - SMS (early experimentation)

Members receive information about eligibility for participation, the process for using services, and how to opt in or opt out of programs and services. For all members, including those who do not have internet access, Oscar mails Welcome and Renewal kits to any new or returning Oscar member at the start of the year. These kits include detailed information about the ARHSP programs and services that members may be eligible for through Oscar as well as other key features of their plan and how to use them.

### Supporting Improved Health Outcomes for Members in Rural Areas

Oscar recognizes the health disparities that exist among rural communities relative to their urban counterparts, and the importance of this in a state like Arkansas with such a large percentage of its total population living in rural areas. Oscar intends to support members in rural communities in two ways: (a) providing referrals to community resources as appropriate when SDoH gaps are identified and (b) through improved access to services via virtual care.

As noted above, SDoH assessments are incorporated into several of Oscar's programs. Items on the assessment include, but are not limited to, elements related to transportation, food insecurity, housing insecurity, social support and medication access. The results will be used to connect members to community resources or their local Rural Life 360 HOME as appropriate.

Oscar's rural members will also have 24/7/365 access to telemedicine services for both medical and behavioral health needs. For medical services, Oscar has integrated telemedicine into its mobile and web applications for simplicity of member access. Members can simply click a button to be connected to a telemedicine provider capable of managing most common urgent medical conditions, issuing medication refills or just providing education and reassurance. The service uses store-and-forward technology, including sharing of images, that allows for both synchronous teleservices or asynchronous consultations via secure messaging. Members can provide the name of their PCP and request that records be shared following the visit. Members can also access telemedicine services by calling their Concierge Team.

Telemedicine services for mental health and substance use conditions are provided through Oscar's partnership with Optum Behavioral Health, which offers telemedicine services through its platform. In addition to many of the individual providers offering telebehavioral health

services, the Optum network also features a number of major telebehavioral health vendors, including AbleTo, American Well, DoctoronDemand, and others. Oscar has also arranged for members to be able to access telebehavioral health from the DoctoronDemand platform directly for members who prefer or find it easier to use that instead of the Optum platform. Provider types available by telebehavioral health through Optum include both prescribers as well as non-prescribers representing a range of license types.

For both of the above, it will be important to ensure members in rural communities engage with Oscar. In particular, digital engagement will be an important first step in enabling improved access through telemedicine services. To promote this, Oscar will incentivize member engagement by offering a $25 gift card to members who create an online account.

### Additional Activities Which Support Members with Mental Illness and Substance Use Disorders

As noted above, Oscar contracts with Optum Behavioral Health, a specialized managed behavioral healthcare organization, to provide access to services for members with mental health and substance use disorders. Some of the programs and initiatives Oscar and Optum collaborate on to support these members include:

1) "Express Access Providers" - Behavioral health providers who are committed to offering appointments within 5 days of a request. They have a special designation in the provider directory to ease identification by members.

2) Telebehavioral health - Improved access and convenience for members needing behavioral health services. See the above section for more detail.

3) Medication Assisted Treatment - Optum provides access to providers with expertise in Medication Assisted Treatment (MAT) to treat substance use disorders as well as sustain recovery and help prevent overdose.

4) Case management - The aim of Optum's Behavioral Health Case Management model is to help members achieve and maintain recovery from mental health and substance use disorders with an individualized, holistic approach to care. Optum's flexible case management approach provides varying types and intensities of support and interventions depending on member need. Further details about this program are described above in the "ARHSP Programs and Services" section.

5) Integrated Medical-Behavioral "rounds" - Case management teams at Optum and Oscar coordinate care for high-risk members enrolled in medical and behavioral health case management. Oscar has a designated nurse case manager who coordinates with Optum case managers through regular case conferences as well as data sharing via a shared data platform to review admissions, discharges, transfers and general case notes.

6) Dedicated behavioral health landing page on member website - Oscar provides members with a dedicated page where they can learn about behavioral health conditions, learn about their behavioral health benefits and search for providers.

7) Self help tools - Optum's member portal, liveandworkwell.com, allows members to find a provider who will best fit their needs based on detailed search capabilities, including areas of expertise, treatment types, and culturally competent care. Liveandworkwell.com also offers tools and resources that members may freely access, including videos to learn about mental health, self-assessment tools for anxiety and depression, and guides and articles about wellness topics like coping with grief, aging, and mindfulness.

8) Member satisfaction survey - A survey conducted annually with members to understand and evaluate their experience with access, availability and services.

9) Language and cultural analysis - An annual assessment of language and cultural needs of the population and the ability of the network to meet those needs.

Oscar additionally implements a number of proactive and reactive programs and policies through its pharmacy benefit manager, CVS, to help optimize the safety of prescribing and using opioids. These activities include:

- Limiting opioid naive members to a 5-day supply of opioids and requiring members to have tried an immediate release opioid before an extended release opioid.
- Implementing point of sale safety edits and provider messaging to decrease initiation of concurrent opioid, muscle relaxant, and/or benzodiazepine therapies. This program also alerts providers when a patient is receiving controlled substance prescriptions from multiple prescribers.
- Implementing a safety edit that requires prior authorization when a member's total opioid intake exceeds 90 morphine milliequivalents.
- Eliminating authorization requirements for initiating and maintaining buprenorphine therapy to increase access to treatment for substance use disorders.

### Incentives and Activities Supporting Economic Independence Initiative

Oscar is committed to assisting members reach economic independence. Through their care teams, members will be able to request information to support them in their goal for economic independence. For those members who take steps to achieve economic independence (e.g. attend a job fair, take classes that support education or job training or financial management) In addition, we will provide economic incentives in the form of a $25 gift card after a qualifying activity is completed.

### Additional Activities Which Support Oscar's ARHSP

Oscar works closely with its practitioners to achieve population health goals. These activities include, but are not limited to:

- Data and Information Sharing with Practitioners[30]:
    - To support practitioners in meeting population health goals, Oscar provides all practitioners in its network access to its Provider Portal which allows them to interact with the clinical dashboard for members for whom they provide care. The clinical dashboard is a tool that empowers practitioners by giving them a dynamic view of their patients' health journeys, including a bird's-eye view into a patient's health history that flags clinically relevant information. The dashboard, which practitioners can log into through their web browser, synthesizes a patient's self-reported health history, past doctor's visits, lab results, active and past prescriptions, hospital admission and discharge alerts, and telemedicine notes into a readable, complete picture of a patient's health. Specific data categories include:
        - Demographic categories, family history, conditions, provider visits/care received, lab results, prescriptions, allergies, plan information (benefits, cost-share, deductible)

- Evidence-Based Clinical Practice and Preventive Health Guidelines: [31]
    - To support practitioners' use of the most current evidence-based standards of care, Oscar utilizes network participating practitioners and other specialists in quality committees to approve, adopt, and distribute evidence-based clinical practice guidelines for medical conditions. Clinical practice guidelines provide evidence-based criteria which providers can use to follow appropriate standards of care which can improve performance for preventive services as well as other common acute and chronic conditions our members face. Practitioners have the ability to view evidence-based practice guidelines via the provider manual which is available publicly on Oscar's provider website.

- Value-based Payment Arrangements:[32] [33]
    - Oscar has implemented value-based payment arrangements with partners in the state. These arrangements include financial and quality components to ensure that practitioners are incentivized to continuously improve the care they provide our members.

## Impact Evaluation for Programs and Services[34]

Oscar will use a systematic approach for evaluating the impact of its ARHSP. This annual report will be a summary of the impact of Oscar's ARHSP on care process or outcome, cost/utilization and member experience. The report will include the following:

1. Quantitative analysis and trending of measures used to assess and improve the member experience

[30] NCQA HPA 2021 Standards PHM.3A.1
[31] NCQA HPA 2021 Standards PHM.3A.6
[32] NCQA HPA 2021 Standards PHM.1A.3
[33] NCQA HPA 2021 Standards PHM.3B
[34] NCQA HPA 2021 Standards PHM.6A-B

2. Qualitative or barrier analysis of program metrics and results against established goals
3. Description of activities and opportunities for improvement

Oscar will also use the ARHSP in its quality improvement efforts through monitoring and taking actions to improve continuity and coordination of medical care across its delivery system. Oscar collects data on member movement between practitioners and settings. Next, it conducts quantitative and causal analyses to identify and select distinct opportunities for improvement. Oscar annually takes action using various programs to improve coordination of medical care and measure the effectiveness of the improvement actions.[35]

## Appendix

### A. The Evidence Base for Care Management

Clinical Practice Guidelines[36]

Introduction
Oscar is committed to the philosophy that Evidence Based Guidelines are known to be effective in improving health outcomes. To that end, we have compiled a group of recognized resources that promulgate Evidence Based Clinical Practice Guidelines.

Case Management Society of America. (2016) Standards of Practice for Case Management. Little Rock, Arkansas

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Lee DS, Stukel TA, Austin PC, et al. Improved outcomes with early collaborative care of

[35] NCQA HPA 2021 Standards QI.3.A-C
[36] NCQA HPA 2021 Standards PHM.5B.1

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## Regulatory References

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