oscar

Program Description: Population Health Management Strategy

Policy Number: PH-001-All

Owners	Applicable Lines of Business	
Business Owners: [redacted] Program Owners: [redacted]	☐ All ☑ On Exchange ☑ Off Exchange ☑ Individual ☑ Small Group ☑ Self-Insured ☐ Internal ☑ TPA/URA	☑ All ☐ Alabama ☐ Arizona ☐ Florida ☐ Georgia ☐ Illinois ☐ Iowa ☐ Kansas ☐ Michigan ☐ Mississippi ☐ Missouri ☐ Nebraska ☐ New Jersey ☐ New York ☐ North Carolina ☐ Ohio B ☐ Ohio C ☐ Oklahoma ☐ Pennsylvania ☐ South Carolina ☐ Tennessee ☐ Texas ☐ Virginia

Status & Details	Review & Revision History		
	Type	Version	Date
Status: Approved Effective Date: 2025.05.06 Latest Review Date: 2024.05.13 Retired Date: N/A	Original[1][2]	1	2018.05.23
	Revised	2	2018.11.12
	Revised	3	2018.12.27
	Revised	4	2019.12.2
	Revised	5	2020.08.18
	Revised	6	2020.12.31
	Revised	7	2021.03.16
	Revised	8	2022.03.21
	Revised	9	2023.05.18
	Revised	10	2024.05.13

[1] The Population Health Management Strategy replaces the Complex Case Management Program policy [CM-001], as well as the Case Management Program policies for Ohio [CM-003-OH]

[2] The Population Health Management Strategy replaces the Cardiac Care program description, as well as the Diabetes Care Management program description

	Revised Revised	11 12	2025.05.06 2026.

Policy Summary[3]

The Population Health Management Strategy outlines the scope, structure, goals and objectives of Oscar's Population Health Management program.

This document describes Oscar's Strategy for managing the health of its enrolled population. It provides an overview of how data is integrated from numerous sources, the needs of the population are identified and stratified for intervention, the population health management (PHM) programs used to address the needs of the population across the entire health and illness continuum and explains enabling strategies used by the health plan to promote the transition to value-based care in its contracted network.

Population Assessment[4]

To create new population health 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, health risk assessment are used annually 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[5] — including an impact analysis of relevant social determinants of health, such as subsidy status, primary language, and racial/ethnic group, multiple chronic conditions.
- 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 based on the enrolled product lines. Children and adolescents' needs are analyzed separately from adults.[6]
- Evaluation of health conditions — such as the needs of members with disabilities[7] and/or members with serious mental illness (SMI) and serious emotional disturbance (SED).[8]
- Evaluation of the needs of members of racial or ethnic groups[9];
- Evaluation of the needs of members with limited English proficiency[10]; and
- Identification of at least two subpopulations and evaluation of at least two needs for each subpopulation.[11]

[3] NCQA HPA 2026 Standards PHM.1
[4] NCQA HPA 2026 Standards PHM.2B
[5] NCQA HPA 2026 Standards PHM.2B.1
[6] NCQA HPA 2026 Standards PHM.2B.2
[7] NCQA HPA 2026 Standards PHM.2B.3
[8] NCQA HPA 2026 Standards PHM.2B.4
[9] NCQA HPA 2026 Standards PHM.2B.5
[10] NCQA HPA 2026 Standards PHM.2B.6
[11] NCQA HPA 2026 Standards PHM.2B.7

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources. Modifications to program activities and resources are made based on these findings.[12] Analysis of the data is used to identify health care disparities among members of racial or ethnic minority groups and members with limited English proficiency and changes are made to at least one PHM program, service, activity or resource annually to address the identified health care disparity.[13] In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan.[14]

Commitment to Health Equity[15] [16]

Oscar is committed to improving health equity. Our organization promotes health equity by designing programs based on the geographic, demographic, and/or socio-economic needs of the population the intervention is targeted towards. Specifically programs & interventions are evaluated and designed examining the accessibility of the program across various parameters which can include (but are not limited to): language, geography, financial, disability (seeing and hearing impaired), and possibly other social determinants of health.

Beginning in 2022 we implemented a multifaceted approach to address the identified disparity in HEDIS® Colorectal Cancer Screening (COL) measure in the Asian community by race/language with the White reference group. The 2021 Health Equity Report's analysis revealed that the Asian group was one of the lowest performing groups with completing their COL screening. Asian Americans are the only racial/ethnic group in the U.S. for whom cancer is the leading cause of death in men and women, unlike heart disease for all other groups. Research literature has shown the Asian population to experience hardship in accessing culturally appropriate care due to language barriers and lack of available interpreter services. Beyond that, the research has shown that Asian Americans are the population least likely to have seen a physician within 12 months, due largely to a cultural norm which is less accepting of screening for disease in the absence of symptoms. Given the identified disparities for the Asian subgroup within both our Health Equity Committee and our National rates, the Asian subgroup was selected as the intervention population to address the perceived disparity in colorectal cancer screening rates.

When stratified by Language, COL compliance at the national level is consistent with the findings reported above with regard to racial disparities.

To address the colorectal cancer screening disparity for the Asian population, Oscar will create family-first "collectivist" messaging, based on research on messaging that resonates with the Asian American population, This messaging includes educational information about the importance of preventive cancer screening, such as email/mail reminders. Additionally, the Plan will partner with our vendor to provide information about Colorectal Cancer Screening in Chinese, Korean and Vietnamese. The statistically significant reduction in the rate of disparity

[12] NCQA HPA 2026 Standards PHM.2C.1-2
[13] NCQA HPA 2026 Standards PHM.2C.3
[14] NCQA HPA 2026 Standards PHM.2C.4
[15] NCQA HPA 2026 Standards PHM.1A.6
[16] NCQA HPA 2026 Standards PHM.6A.1-3

between the Caucasian (reference) population and the Asian populations in the HEDIS® measure for colorectal cancer screening (COL) will serve as our indicator of success and quality improvement.

In addition, we will ensure all providers within Oscar's network, especially primary care providers, have access to cultural competency training focused on the delivery of culturally and linguistically competent services and the implementation of the National Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. CLAS fundamentals include delivering patient-centered care, how to effectively work with an interpreter, and organizational CLAS-related activities including strategic planning and community assessments.

Culturally Competent Care Grantees (Activities that support community based organizations)
The CCC Grant Program, launched by Oscar Health in 2021, aims to support community organizations that work to increase access to culturally competent healthcare in underserved communities, addressing disparities in access to care and improving clinical outcomes.

Population Stratification and Segmentation[17]

Oscar combines data from multiple sources to use in its population stratification and program eligibility process.

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[18]
2. Pharmacy claims[19]
3. Laboratory results[20]
4. Health appraisal results[21] [22]
5. Electronic health records[23]
6. Health services programs within the organization: utilization management, care management[24]
7. Health information exchanges (HIEs)[25]
8. Advanced data sources[26]
9. Medecision Health Status Measure (HSM)[27]

---

[17] NCQA HPA 2026 Standards PHM.2
[18] NCQA HPA 2026 Standards PHM.2A.1
[19] NCQA HPA 2026 Standards PHM.2A.2
[20] NCQA HPA 2026 Standards PHM.2A.3
[21] NCQA HPA 2026 Standards PHM.2A.4
[22] 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.
[23] NCQA HPA 2026 Standards PHM.2A.5
[24] NCQA HPA 2026 Standards PHM.2A.6
[25] NCQA HPA 2026 Standards PHM.2A.7
[26] NCQA HPA 2026 Standards PHM.2A.8, State Immunization Records
[27] Medecision (Aerial) is an EHR vendor that uses a HSM score as a risk stratification tool to highlight members potentially needing a higher level of care.

Elements of the above data are incorporated 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 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 in real-time.[28]

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[29]

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

[28] NCQA HPA 2026 Standard PHM 2D.1
[29] NCQA HPA 2026 Standard PHM 2D.1

Healthy	Member who do not meet criteria for any of the other segments Member may have active health issues, but that confer little risk 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 for new members, clinical segmentation cannot be determined and member is labeled "Unknown"

Oscar provides an annual report displaying the number of members for each PHM program members are eligible for as well as the percentage of total enrolled member population in its Population Health Impact Evaluation Report.

Oscar assesses for racial bias in its segmentation methodology through examining the populations targeted for enrollment into select PHM programs (e.g. Complex Case Management) and comparing the statistical distribution of racial demographics to the overall Oscar population to promote equitable program access and identify possible racial biases that may exist in the segmentation model.[30]

A description of subsets and the type of intervention offered to members is described in the PHM Programs and Services portion of this document below.

PHM Programs and Services Overview[31] [32]

Oscar offers the following PHM programs and services to its enrolled members:

Overview of Oscar's PHM Programs and Services[33] [34]

Focus Area	Program Name	Eligible Population	Product Line
Keeping members healthy	Annual Preventive Health Visit Program	Members who are ≥18 years of age by December 31st of the calendar year and not in hospice	Marketplace Commercial
Keeping members healthy	Colorectal Cancer Screening Program	Adults ages 45-75, based on USPSTF criteria, who do not meet HEDIS	Marketplace Commercial

[30] NCQA HPA 2026 Standards PHM.2D

.
[31] NCQA HPA 2026 Standards PHM.1
[32] NCQA HPA 2026 Standards PHM.6A
[33] NCQA HPA 2025 Standards PHM.1A.1-2
[34] NCQA HPA 2025 Standards PHM.6A.1, One clinical measure, one cost utilization measure, one member feedback measure from two different groups.

		exclusion criteria (e.g., history of colorectal cancer, total colectomy)	
Managing members with emerging risk	ER Diversion Program	Members identified as at risk of going to an emergency room via secure message after searching in Oscar's Care Router for immediate care	Marketplace Commercial
Patient safety or outcomes across settings	Post-Hospital Recovery	Members admitted for inpatient events at acute care hospitals for chronic conditions	Marketplace Commercial
Managing multiple chronic illnesses	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	Marketplace Commercial

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 Population Health Programs and Services that members may be eligible for through Oscar.

Members that are eligible for programs that include interactive contact receive program-specific information about how they became eligible to participate, how to use program services and how to opt in or out of the program upon initial contact.

Population Health Management Impact Evaluation

Below we describe in greater detail selected programs that align with each of the four focus areas.

Annual Preventive Health Visit Program	
Eligible population:[35]	Members who have not completed their annual wellness visit in the past 12 months with additional messages for members who have chronic conditions.
Focus area:[36]	Keeping members healthy
Program goal(s:)[37]	Encouraging preventive healthcare visits and achieve: ● Increase in the rate of Preventive visits by 5% over the previous year's performance in each respective state (Utilization measure)

[35] NCQA HPA 2026 Standards PHM.1A.1
[36] NCQA HPA 2026 Standards PHM.1A.1
[37] NCQA HPA 2026 Standards PHM.1A.1

Program services:[38]	Quarterly campaign: Members will enroll once they are 12 months post their last visit. Campaign will primarily consist of digital outreach (email, sms, etc.)
Methods and data sources used to identify the eligible population:	Eligible members are identified through enrollment and claims data.
Activities that support practitioners and providers. :[39]	Collaborating with providers via monthly open gap reports to facilitate identifying members who are attributed to their practice and eligible for screenings.

Colorectal Cancer Screening

Eligible population:[40]	Adults ages 45-75, based on United States Preventive Services Task Force criteria, who do not meet HEDIS exclusion criteria (e.g., history of colorectal cancer, total colectomy)
Focus area:[41]	Keeping members healthy
Program goal(s):[42]	The goals of the program are: ● Increase the rate of colorectal cancer screenings in the IFP populations to the greater of MY2024's 25th percentile* or MY2024 reported rate, and Commercial populations above the 10th %tile (Clinical process measure) :

Region	Product Line	Goal
AZ	Commercial	51.17%
	Marketplace	57.17%
FL	Commercial	51.17%
	Marketplace	42.5%
GA	Commercial	51.17%
	Marketplace	42.5%
IA	Commercial	51.17%
	Marketplace	42.5%
IL	Commercial	51.17%
	Marketplace	42.5%
KS	Commercial	51.17%
	Marketplace	42.5%
MI	Commercial	51.17%
	Marketplace	54.77%

[38] NCQA HPA 2026 Standards PHM.1A.2
[39] NCQA HPA 2026 Standards PHM.1A.3
[40] NCQA HPA 2026 Standards PHM.1A.1
[41] NCQA HPA 2026 Standards PHM.1A.1
[42] NCQA HPA 2026 Standards PHM.1A.1

		MO	Commercial	51.17%
			Marketplace	42.5%
		NC	Commercial	51.17%
			Marketplace	42.5%
		NE	Commercial	51.17%
			Marketplace	42.5%
		NJ	Commercial	51.17%
			Marketplace	42.5%
		NY	Commercial	51.17%
			Marketplace	62.94%
		OH_CLD	Commercial	51.17%
			Marketplace	74.51%
		OH_COL	Commercial	51.17%
			Marketplace	42.5%
		OK	Commercial	51.17%
			Marketplace	42.5%
		PA	Commercial	51.17%
			Marketplace	42.5%
		TN	Commercial	51.17%
			Marketplace	42.5%
		TX	Commercial	51.17%
			Marketplace	42.5%
		VA	Commercial	51.17%
			Marketplace	42.5%
	Benchmarks used are from MY2024 COL- E Total Rate ● Member Experience Goal: At least 50% of respondents, who were enrolled in the program, reported the information provided was useful (Member Experience)			
Program services:[43]	The specific services of this program are: ● Multi-channel member outreach (ex:email, secure message, SMS, etc.) ● Combined health screening and services reminders, including preventive, and chronic condition care. Assistance in care appointment scheduling			

[43] NCQA HPA 2026 Standards PHM.1A.2

	● Members that connect with Oscar Medical Group for Virtual Health Assessments (VHAs) will receive referrals for any necessary screenings. ● In-home testing kits will be sent to members. Follow up reminders will be sent via email and mail. Results are shared with members via mail, portal, and with the assigned primary care provider.
Methods and data sources used to identify the eligible population:	Eligible members are identified through enrollment and claims data. If the member will be older than 45 years of age on the last day of the calendar year they will be included in the campaign, excluding members who have completed colorectal cancer screening, had a total colectomy, are in hospice, or are receiving palliative care.
Activities that support providers and practitioners. [44]	Collaborating with providers via monthly open gap reports to facilitate identifying members who are attributed to their practice and eligible for screenings. Expanding our clinical care data base through providers and vendor sources. Member gaps are available to view in the Provider portal at a member level.
Member Notification for Enrollment:[45]	Members are contacted via live telephonic outreach, non-identified e-mail / SMS messages. Members are given the ability to opt out from future reminders and / or outreach.

ER Diversion Program	
Eligible population:[46]	All members.
Focus area:[47]	Steer members to appropriate care utilization to reduce misuse of the emergency room and manage members with emerging risk.
Program goal(s):[48]	The specific goal of this program is to: ● Reduce avoidable member visits to the emergency room by 1%.
Program services:[49]	The specific services of this program are: ● Virtual urgent care appointment scheduling ● Messaging campaigns to route members to appropriate site of care (PCP, Urgent Care, ER)
Methods and data sources used to identify the eligible population:	● All members at Oscar to help remind them before they have an ER event. We have found that you can influence behavior before an event better than post an ER event.
Activities that support providers and practitioners. :[50]	Oscar's HEDIS Manager shares standardized patient-level detail and provider performance on a monthly basis. This details AWV compliance, as well as HEDIS and Med Adherence opportunities. Our cross-functional internal teams regularly discuss the opportunities and drive our members to their PCPs to complete AWVs and appropriate care gap closure, in part to decrease reliance on urgent and emergent care facilities. This also includes

[44] NCQA HPA 2026 Standards PHM.1A.3
[45] NCQA HPA 2026 Standards PHM.1B.1-3
[46] NCQA HPA 2026 Standards PHM.1A.1
[47] NCQA HPA 2026 Standards PHM.1A.1
[48] NCQA HPA 2026 Standards PHM.1A.1
[49] NCQA HPA 2026 Standards PHM.1A.2
[50] NCQA HPA 2026 Standards PHM.1A.3

	direction on how to find care, importance of preventive care, and how their benefits cover access to this care. Oscar's Joint Operating Committee (JOC) conducts quarterly meetings with provider partners with Value Based Care agreements to review HEDIS measures and their respective performance records.
Member Notification for Enrollment:[51]	ER Diversion Program members are outreached by secure messages and notified about how they were identified for outreach and program services. Our ongoing multi-channel campaigns include email-based monthly education to all members, as well as targeted messaging to more segmented groups that drives saliency and relevance on top of the proactive education.

Post Hospital Recovery	
Eligible population:[52]	High-risk members identified via a predictive readmission model who are admitted for inpatient events at acute care hospitals for chronic conditions.
Focus area:[53]	Patient safety or outcomes across settings
Program goal(s):[54] [55]	The overall purpose of the program is to reduce readmission rate for eligible population by intervening with members after high-priority admissions to ensure recovery plan adherence. Primary measures and program goals are listed below: ● Member Experience (member satisfaction): Achieve $\geq$80% overall member satisfaction score. ● Readmissions within 30 days of discharge: Achieve a >2% delta (negative) between the readmission rate for our enrolled-outcome achieved population compared to our non-enrolled population
Program services:[56]	Case Managers will work with members to ensure adequate care and documentation; outpatient provider follow-up; medication regimen optimization; and self management of health conditions.
Methods and data sources used to identify the eligible population:	Oscar has established direct feeds with health system partners to capture real-time ADT discharge data from the systems' electronic health records (EHRs). Oscar also identifies eligible members through internal and provider referrals.
Activities that are not direct member interventions:[57]	Collaborating with hospitals, providers and vendors, identification of gaps in care, and obtaining social and physical resources to improve patient health outcomes and prevent readmissions.
Member Notification for Enrollment:[58]	Members are informed of eligibility via telephone call, secure message, or a mailed outreach letter (if no email on file) from the case management team.

[51] NCQA HPA 2026 Standards PHM.1B.1-3
[52] NCQA HPA 2026 Standards PHM.1A.1
[53] NCQA HPA 2026 Standards PHM.1A.1
[54] NCQA HPA 2026 Standards PHM.1A.1
[55] NCQA HPA 2026 Standards PHM, 6A.2
[56] NCQA HPA 2026 Standards PHM.1A.2
[57] NCQA HPA 2026 Standards PHM.1A.3
[58] NCQA HPA 2026 Standards PHM.1B.1-3

	Members must agree to participate in the program for enrollment to proceed and have the option to opt out upon request at any time.

Complex Case Management (CCM)	
Eligible population:[59]	A Member is eligible for the CCM program if they meet one or more of the following criteria: ● 1+ chronic or complex condition that is not well managed. ● Multiple chronic conditions with no providers or medication in place and/or noted non-adherence to treatment plan ● 3+ ER visits and/or 3+ IP admissions in 6 months ● High dollar utilization: $25k or greater in 6 months (excluding medications) ● Identified as part of a high-risk cohort using a Milliman predictive risk model. OMC may broaden or adjust their identification criteria for members identified through data-directed surfacing as necessary based on organizational and population need.
Focus area:[60]	Managing multiple chronic illnesses
Program goal(s):[61] [62]	The goals of this program are: ● Member experience (member satisfaction) : Achieve ≥80% overall member satisfaction score ● PCP Visits: At least 50% of enrolled CCM Members will have a PCP visit within 90 days of program enrollment
Program services:[63]	● Comprehensive assessment of member's physical, behavioral, psychosocial and support needs (SDOH/Caregiving needs) ● Determination of available benefits and resources ● Development and implementation of Case Management Plan with prioritized goals, monitoring and follow-up. ● Interventions may include but are not limited to: ○ Intensive care coordination services ○ Health education and support for members/caregivers to improve self-management skills for complex and/or chronic health conditions. ○ Member outreach by phone, secure messaging (accessed through email) and mail ○ PCP/Specialist routing ○ Community resource referral, as needed
Methods and data sources used to Identify the eligible population:	● Clinical Care Team referral ● Hospital Discharge Planners ● Medical Management referral (UM referral) ● Practitioner referral ● Provider Partner referral ● Member or Caregiver referral

[59] NCQA HPA 2026 Standards PHM.1A.1
[60] NCQA HPA 2026 Standards PHM.1A.1
[61] NCQA HPA 2026 Standards PHM.1A.1
[62] NCQA HPA 2026 Standards PHM.6A.2
[63] NCQA HPA 2026 Standards PHM.1A.2

	● Data-directed Surfacing
Activities that support providers and practitioners.[64]	Collaborating with hospitals, provider groups, health systems and vendors to improve patient health outcomes and foster smooth transitions of care between settings.
Member Notification for Enrollment:[65]	Members are notified of the availability of the complex case management program in a document contained within the welcome kit provided to all new members, along with a number to call if they feel they need support managing complex health care needs. There is also information on the public website regarding case management programs with information on how to self-refer. These materials tell members that the CCM program is completely voluntary and that members may opt out at any time by notifying the Oscar team member that is contacting them for participation in the program. Members that are referred to CCM by their Oscar Case Manager are educated about the program services at the time of referral, when feasible, and have the opportunity at that time to accept or decline that referral. Members identified by Oscar as being eligible for Complex Case Management receive outreach by telephone, secure message and/or a mailed engagement letter if they have no email on file.

Activities Which Support PHM Programs and Services[66] [67]

In addition to the member outreach programs outlined above, Oscar also conducts the following activities to support its PHM programs and services. These activities are targeted at supporting network practitioners and providers in the transition to value-based care and include the following:

- Data and Information Sharing with Practitioners:[68]
    - 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 they provide care for. 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 admits 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).

[64] NCQA HPA 2026 Standards PHM.1A.3
[65] NCQA HPA 2026 Standards PHM.1B.1-3
[66] NCQA HPA 2026 Standards PHM.1A.3
[67] NCQA HPA 2026 Standards PHM.3
[68] NCQA HPA 2026 Standards PHM.3A.2

- Alternative Payment models :[69] [70]
    - Oscar has implemented a number of alternative based payment models with partners across our markets. These arrangements include financial and quality components to ensure that practitioners are incentivized to continuously improve the care they provide our members.

Case Management

Oscar informs members and providers of the Population Health programs that members are eligible for, including programs such as post-hospital recovery and complex case management programs through plan documents, online provider access and verbal conversations. Once members are enrolled in the complex case management program and develop a care plan, the case management team shares the care plan with the members' Primary Care Provider, with the member's permission, via fax or other electronic methods. This data sharing encourages timely and robust engagement between the provider, the member, and the case manager to ensure that all parties are partnering effectively to ensure that the member receives the care coordination they need to manage their health effectively and achieve their care plan goals.

Oscar informs members of its Population Health programs through:

- Mailing plan documents in new member welcome packet *When they come on the plan*
- Online in plan documents and population health form *24/7 on hioscar.com*
- Live conversations - verbally, secure messaging, etc. *When they enroll a new member or it comes up in conversation.*

Utilization - Pharmacy Sharing

In collaboration with CVS, Oscar monitors the UOP HEDIS® measure, which assesses the rate of members, 18 or older, who receive opioids from 4 or more practitioners or pharmacies during the measurement. This measure allows Oscar to proactively engage with and coordinate with members and prescribers who may be at risk for opioid overuse and misuse. Oscar believes it can play a crucial role in ensuring patients have access to safe and effective chronic pain treatment through effective coordination, monitoring and outreach to prescribers and pharmacies, as necessary.

In partnership with Oscar's Pharmacy Team, CVS Health conducts its Safety and Monitoring Solution which targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping and high-total controlled substance claims volume. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication

[69] NCQA HPA 2026 Standards PHM.1A.3
[70] NCQA HPA 2025 Standards PHM.3B

- Providing practice transformation support to primary care practitioners:[71]
    - o To support practitioners in becoming a more-integrated or advanced practice which will contribute to Oscar's population health goals, Oscar provides education to its practitioners on best practices for migrating into value-based payments and support patients as part of those contracts.

Roles and responsibilities for providers for collaborative care

- Providers will participate in Care Management programs established by Oscar and collaborate in creating member care plans and reassess as required to support member needs. Oscar may use Provider, Provider Entity and Employed Professional performance data for Care Management. Further, Provider agrees to participate in government and/or accreditation entity programs that require Provider to participate and/or provide applicable data or other information (e.g., HEDIS, NCQA, CMS programs). Subject to applicable Laws, Provider will provide to Oscar or its designee, copies of health records or access to electronic health records and other information as reasonably required by Oscar, and according to timeframes set by Oscar, to issue Authorizations, determine Medical Necessity and administer clinical programs. Practitioners are informed about care management in the provider manual and can refer members by advising them to call 1-855-OSCAR-55 to enroll in the program. Provider groups/health systems established as Oscar partners can refer members to care management via email or by direct communication during established meetings with the Case Management team.

- Cultural Competency Resources:[72]
    - o To support practitioners in delivering high-quality culturally sensitive services, Oscar provides practitioners in its network with e-learning offered by the U.S. Department of Health and Human Services free of charge. This training equips providers with the necessary competencies to improve the quality of treatment for our diverse member population. Additionally, Oscar encourages providers to utilize this training to learn more about how to improve their interaction with members who have specific language or ethnic preferences. Information about this e-learning is communicated annually through the Provider Manual and is available on Oscar's Provider site.
- Evidence-Based Clinical Practice and Preventive Health Guidelines:[73]
    - o 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 on cervical cancer screening, colorectal cancer screening and HbA1C testing as

[71] NCQA HPA 2026 Standards PHM.3B.1
[72] NCQA HPA 2026 Standards PHM.3B.4
[73] NCQA HPA 2026 Standards PHM.3B.1

well as other common issues our members face. Practitioners have the ability to view evidence-based practice guidelines via the state provider manuals which are available publicly on Oscar's provider website at provider.hioscar.com/resources.

-

Coordination of Member Programs [74]

Oscar uses the following tactics to coordinate across member programs and services, including programs members may receive through their provider care team:

- Upon enrollment, each Oscar member is assigned to a care team. Care Teams consist of RN and Social Worker Case Managers, Clinical Support Specialists, Community Health Workers and Care Guides. Oscar care teams work together to support members, their caregivers, and providers in coordinating member care and services across a variety of settings, providers and levels of care. When a member contacts Oscar, they get connected to the appropriate Care Team member for their specific concern, leveraging a complete picture of the member's health and history with Oscar.
- RN and SW Case Managers focus on addressing clinical concerns. They collaborate with the rest of the Care Team to provide comprehensive services such as benefit education, in-network PCP and specialist referrals, care coordination, condition management support, and medical, behavioral health and SDOH resources. These services ensure members transition through settings of care smoothly, enabling them to access the appropriate health care services and providers they need to achieve optimal wellness and avoid health care complications that can lead to unnecessary utilization.
- Oscar's virtual health services are similarly integrated with other Oscar PHM programs. For example, Care Guides or Case Managers on Care Teams can connect members to Oscar's virtual health services. Data related to member's virtual health calls are ingested in Oscar's core data infrastructure and can be combined with other utilization information about members.

Informing Members and Providers about Available PHM Programs[75] [76]

Oscar uses multiple methods to inform members about the various Population Health Programs and Services offered:[77]

- Through direct outreach by Care or other Oscar outbound teams, members receive information about eligibility for participation, the process for using services, and how to opt in or opt out.[78] [79]
- Members who prefer to use web or mobile devices can access www.hioscar.com/forms.[80]
  Providers are informed via the Provider Manual (link) Oscar Provider Manual

[74] NCQA HPA 2026 Standards PHM.1A.4, PHM. 3A.1
[75] NCQA HPA 2026 Standards PHM.1A.5
[76] NCQA HPA 2026 Standards PHM.1B
[77] NCQA HPA 2026 Standards PHM.1A.5
[78] NCQA HPA 2026 Standards PHM.1A.5
[79] NCQA HPA 2026 Standards PHM.1B
[80] NCQA HPA 2026 Standards PHM.1B.2-3

Oscar uses a systematic approach for evaluating the impact of its Population Health Management strategy. The annual report is a summary of the impact of Oscar's population health management programs for each of the care process, outcome, cost/utilization and member experience measures.[81] The report includes the following:

1. Quantitative analysis and trending of measures used to assess and improve the member experience[82]
2. Qualitative or barrier analysis of population health management program metrics and results against established goals[83]
3. Description of the comprehensive population health management activities and a comprehensive assessment of its overall PHM strategy.[84]

Oscar uses the results of this Impact Evaluation report to gather insights about the effectiveness of individual programs, the impact on areas of focus, and the overall PHM strategy. Next, it conducts quantitative and causal analyses with relevant stakeholders and program owners to identify two opportunities for improvement.[85] Additionally, Oscar acts on at least two identified opportunities for improvement.[86]

[81] NCQA HPA 2026 Standards PHM.6A.1-3
[82] NCQA HPA 2026 Standards PHM.6A.1
[83] NCQA HPA 2026 Standards PHM.6A.2-3
[84] NCQA HPA 2026 Standards PHM.6
[85] NCQA HPA 2026 Standards PHM.6B.1
[86] NCQA HPA 2026 Standards PHM.6B.2