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The next frontier in Value-based contracting

Navigating excellence and sustainability in New Mexico's unique healthcare landscape

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New Mexico HMFA

Jeremiah Reuter FCA, ASA, MAAA
Vice President, Optum

Agenda

1. Introduction
2. National landscape of value-based contracting
3. New Mexico’s unique healthcare landscape
4. The current state of value-based care
5. Discussion & closing remarks

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First, let's define key terms

VOLUME x PRICE

Fee-for-service

- Success measured by maximizing volumes and revenues
- Little standardization around clinical evidence and widespread quality and cost variation
- Focus on improving efficiency of acute services

QUALITY / COST

Value-based payment

- Success measured by outcomes
- Integrated care delivery, treatment pathways
- Consistency with evidence-based care and utilization practices
- Focus on reducing total cost of care

6/16/25

CMMI zeroes in on generating cost savings – fast

CMMI's three new strategic pillars aim to do one thing…

01 Promote evidence-based prevention

- Embed preventive care in all models
- Design and regularly evaluate models based on their impact on costs and outcomes

02 Empower people to achieve their health goals

- Improve patients' data access to facilitate informed decision-making
- Increase provider accountability for cost and quality through financial incentives

03 Drive choice and competition

- Support independent providers to increase market competition
- Reduce administration burden of participating in advanced APMs[1]

…protect federal taxpayers

> "The pillars are underpinned by a **foundational principle, which is to protect the federal taxpayer**…
>
> The Innovation Center will focus on models that show the greatest promise for generating savings and improving quality."

Abe Sutton, Director of CMMI

1. Alternate payment models.

Source: See additional sources slide.

Advisory Board interviews and analysis.

6/16/25

Trump 2.0 wants VBC impact on FFS timelines

Three main shifts evident in CMMI's new approach

	From experimentation to fiscal discipline	From optional to mandatory risk-bearing	From health equity to efficiency
Actions taken	Announced early termination of four VBC models[1] and reduced ACO REACH and KCC[2] model payouts in 2026	Kept mandatory TEAM[3] model and signaled new models will shift financial risk from taxpayers to provider organizations	Removed mandatory SDOH[5] screening from AHEAD[6] model and removed equity funding from listed model priorities
Stated intentions	• No tolerance for models without "clear, timely [ROI] for taxpayers" • Focus on models with "the greatest promise for generating savings and improving quality"	Potential requirements for future models: • "All APMs[4] involve downside risk" • "A growing proportion of Medicare and Medicaid beneficiaries [be] in global downside risk arrangements"	• Support of "equity, but not at the expense of efficiency and outcomes" • Aim to empower consumers: "The choice should be one that people [and caregivers] are empowered to make as consumers"
Future implications	• **Shorter timelines** across fewer pilots • **Nation-wide models** • **Immediate fiscal impact** over long-term transformation	• **Mandatory models** to drive accountability • **Downside risk** incentive models • **Providers must take on risk**, not just conveners or intermediaries	• **Equity tied to ROI**, not mission • **Market-based tools** over structural fixes • **Support for independent providers'** participation in risk

1. The four models terminated by the end of 2025 include: Primary Care First, Making Care Primary, End-stage Renal Disease Treatment Choices, and Maryland Total Cost of Care.
2. Kidney Care Choices Model. 2. Transforming Episode Accountability Model. 3. Alternative Payment Models. 4. Social drivers of health. 5. States Advancing All-Payer Health Equity Approaches and Development.

Source: See additional sources slide.

Advisory Board interviews and analysis.

New Mexico healthcare landscape

Gov’t Payer

Medicaid ~40% of population

Medicare ~20% of population

Medicaid coverage losses due to renewal confusion, redetermination

67% support using Medicaid for social needs

Rural Crisis

OB service deserts and hospital closures

Long travel distances and urban hospital strain

Workforce shortages and high labor costs

Cultural Barriers

Lower awareness among Spanish-speaking and Native American populations

Need for culturally tailored outreach

State Performance

Ranked 34th overall in healthcare

Strengths: 4th in dentists, 2nd lowest cancer rate

Weaknesses: 2nd highest at-risk adults without routine care

In 2026, it is projected to shift toward more accountable, equity-informed, and financially sustainable models through Medicaid innovation and federal reform.

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Future Landscape of State Healthcare in New Mexico

Major Medicaid transformation is underway through demonstration waivers and shift to value-based payment

Turquoise Care Section 1115 Demonstration Waiver

Value-Based Care Expansion: The state is shifting toward primary care payment reform and alternative payment models that reward quality and outcomes over volume.

Social Determinants of Health (SDOH): Medicaid will cover non-traditional services like housing supports, nutrition assistance, and transportation to address SDOH.

Behavioral Health Integration: Enhanced focus on integrating behavioral health services into primary care, especially for high-need populations.

Health Equity Focus: The waiver emphasizes reducing disparities in care access and outcomes, particularly for rural and tribal communities.

Financial Impact

Health Equity Focus: The waiver emphasizes reducing disparities in care access and outcomes, particularly for rural and tribal communities.

Anticipated Impact: Improved cost-efficiency and reduced avoidable utilization.

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Despite volatility, the VBC journey continues

Interest in VBC ebbs and flows

"Health care leaders push forward on value-based care amid challenges"

October 2024, AJMC

"Value-based payment has produced little value. It needs a time out"

July 2022, STAT

"Value-Based Healthcare Battle: Kaiser-Geisinger Vs. Amazon, CVS, Walmart"

July 2023, Forbes

"Health system execs see a value-based care tidal wave ahead"

December 2023, Becker's Hospital Review

CMMI[1] model experimentation continues…

50+ models tested

20+ models still active

…with more new models launching

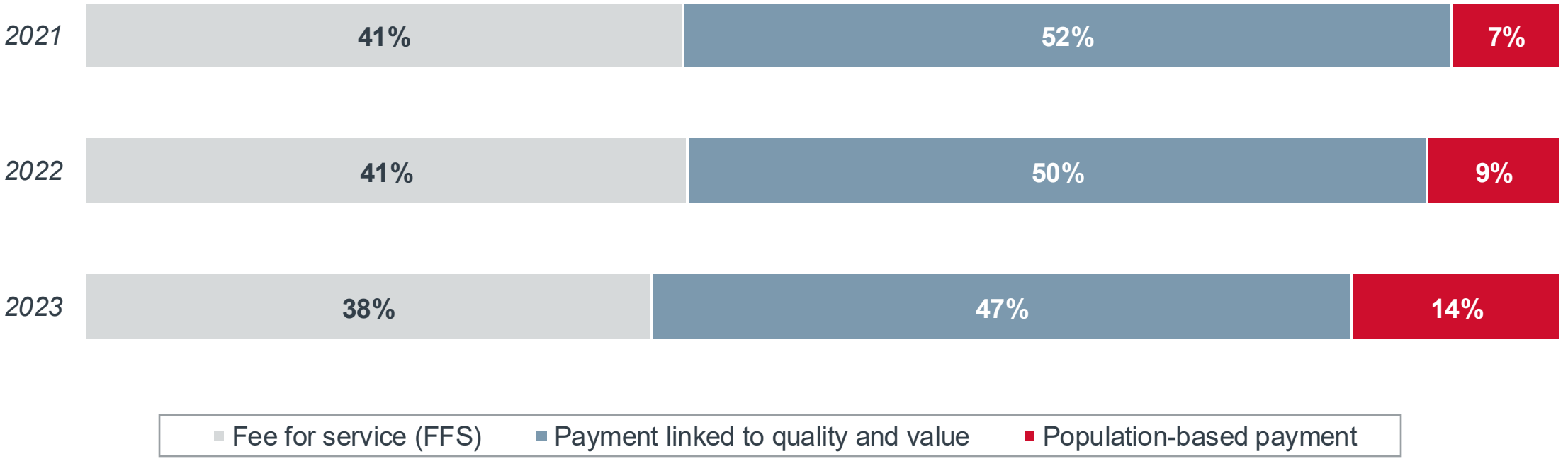
- Transforming Episode Accountability Model (TEAM)
- Accountable Care Organization (ACO) Primary Care Flex
- Transforming Maternal Health (TMaH)
- Innovation in Behavioral Health (IBH)

1. The Center for Medicare and Medicaid Innovation.

Source: APM Measurement Effort. HCP LAN. 2023 & 2018; LaPointe J, "The Most Successful Alternative Payment Models from CMMI, To Date." RevCycle Intelligence. December 2022.

Financial transformation already well underway

Health Care Payment Learning & Action Network (HCP LAN) alternative payment model measurement[1]



1. Percentages for CY 2023 add to 99% due to rounding.

Source: APM Measurement Effort, HCP LAN, 2024 & 2016.

Financial transformation already well underway

Payments made in CY 2023 and percentage point change from payments made in 2018

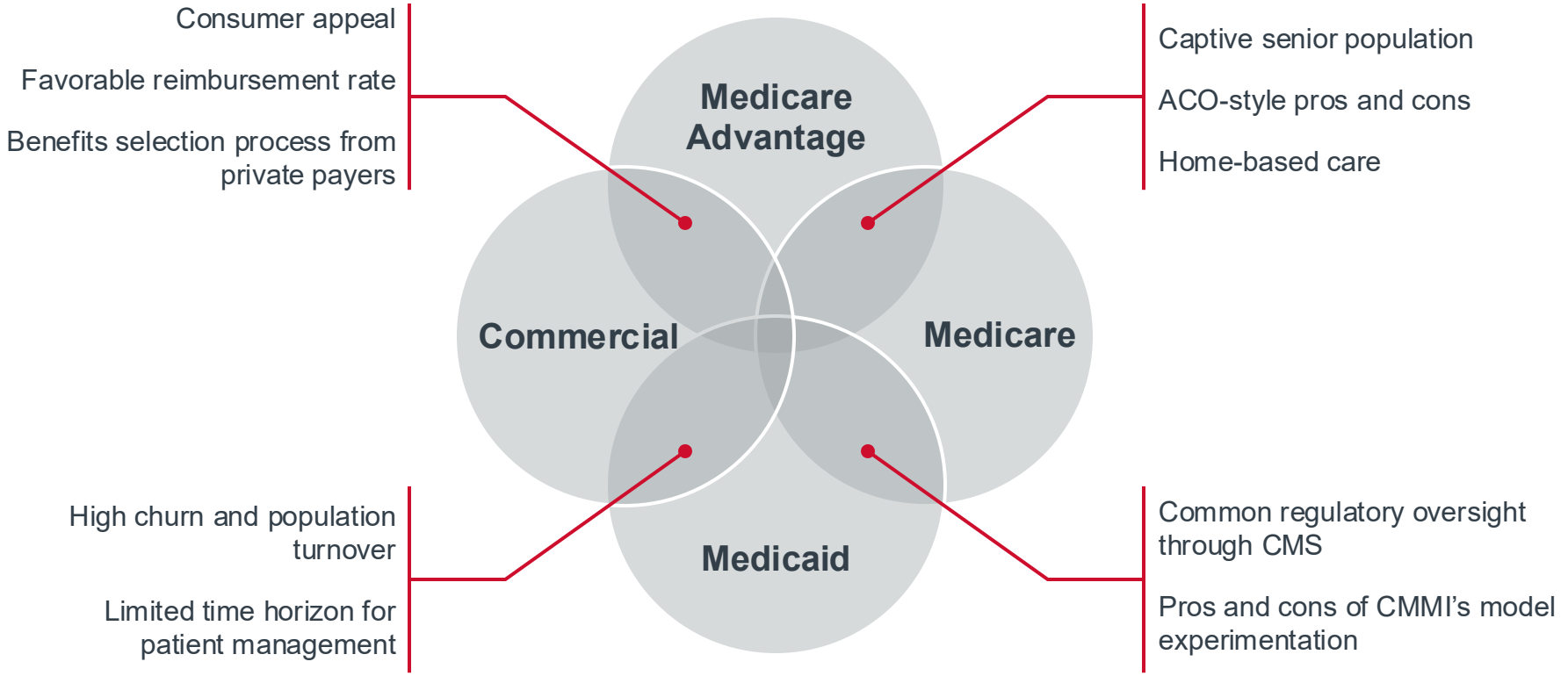
Progression to alternative payment methodology

	Traditional fee-for-service	Fee-for-service linked to quality and value[1]	Shared savings and bundles[2]	Population-based payment[3]
Medicare Advantage[4]	31% -8 pts	4% -3 pts	30% -6 pts	34% +17 pts
Traditional Medicare	17% +7 pts	41% -8 pts	30% -6 pts	12% +8 pts
Medicaid[4]	47% -19 pts	9% -2 pts	34% +17 pts	9% +3 pts
Commercial	50% -6 pts	11% -3 pts	31% +3 pts	8% +6 pts
All-payer	**38%** -1 pts	**16%** -9 pts	**31%** +<1 pt[5]	**14%** +9 pts

1. Includes foundational payments for infrastructure and operations (e.g., care coordination fees) and fee-for-service plus pay-for-reporting payments and pay-for-performance payments.
2. Includes alternative payment models with shared savings with upside risk only and shared savings with downside risk. These are built on FFS architecture.
3. Includes condition-specific payments (e.g., PMPM for oncology or mental health), comprehensive population-based payment (e.g., global payments), and integrated finance and delivery systems (e.g., global budgets).
4. Due to rounding, this totals to 99%, not 100%.
5. Noted as <1 due to 0.3 difference. All other decimals rounded to nearest whole number.

Source: APM Measurement Effort, HCPLAN. 2024 & 2019.

Common VBC (dis)advantages across lines of business



Common across all lines of business

Behavioral health needs

Inequities

Data challenges

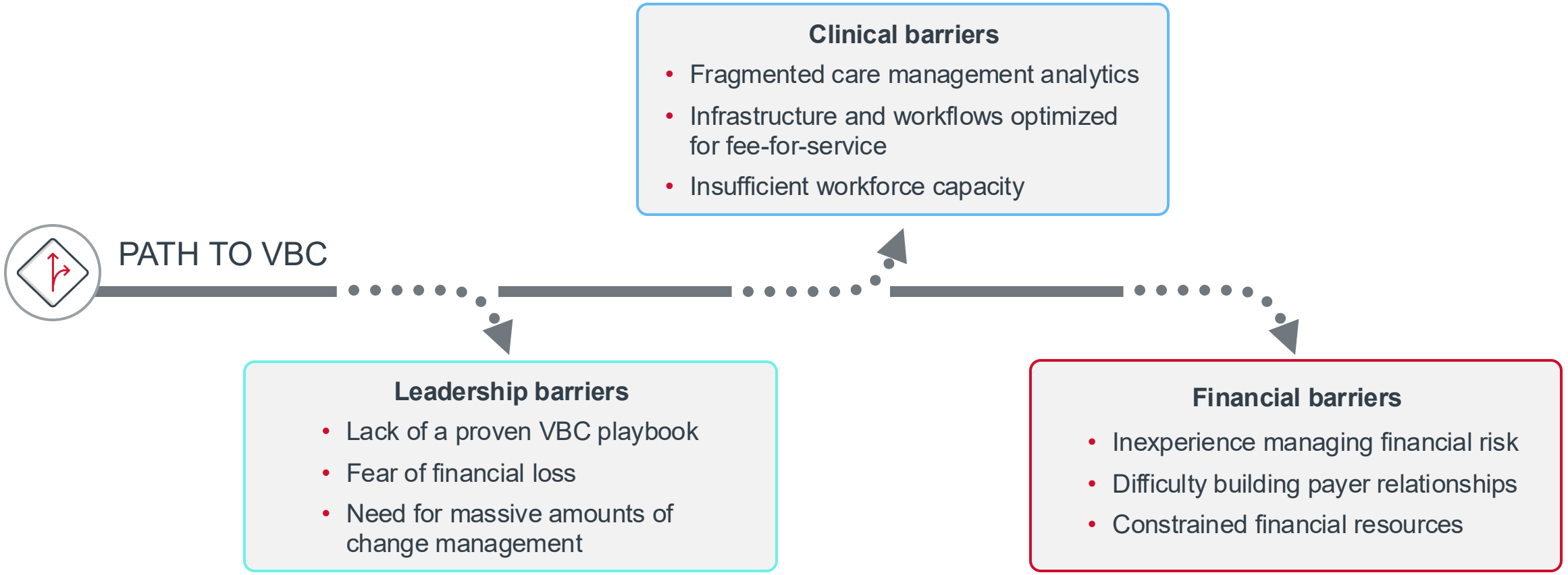
Ambition of VBC is much more than the money

Declining health outlook		Population health initiatives
42% Of Americans have **two or more chronic conditions**	›	Enable **self-management** of patients' chronic conditions
80% Of patients' health outcomes can be attributed to **socioeconomic factors and environment**	›	Address the **wider drivers** of health (not just clinical care)
43% Of adults report feeling **more anxious** in 2024 than the previous year vs. 37% in 2023	›	Surface and address **behavioral health** needs

Source: Benavidez GA, et al., Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area, CDC, February 29, 2024; Magnan S, Social Determinants of Health 101 for Health Care: Five Plus Five, National Academy of Medicine, October 9, 2017; American Adults Express Increasing Anxiousness in Annual Poll: Stress and Sleep are Key Factors Impacting Mental Health, American Psychiatric Association, May 1, 2024.

For most health systems, VBC is a side hustle at best

Roadblocks preventing health systems' expansion of VBC



Providers bearing risk were more likely to make money than lose it

Fear of financial loss remains a top barrier

#1

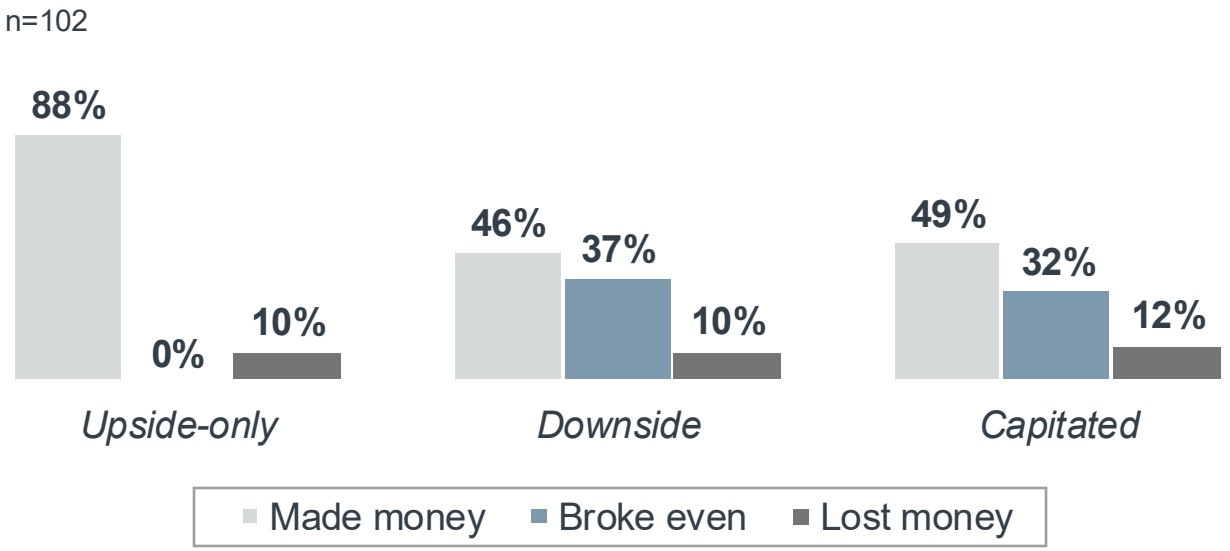
Executives consistently report the threat of financial loss as the top barrier to success in VBC

2x

Executives selected threat of financial loss as a barrier two times more than any other answer choice when surveyed

But only a small minority lost money in VBC last year

"Under [respective risk contract] my organization has..."



Source: Advisory Board 2024 Path to Value Survey.

But yesterday's revenue will not be tomorrow's

Root causes that created the initial momentum for VBC have only intensified

SHIFTING PAYER MIX

Payer mix shifts away from employer, toward government payer

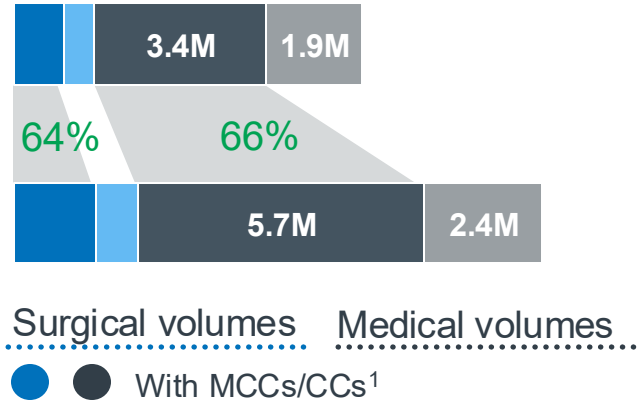
-5.6pt

Decrease in commercial share of HCA Healthcare patient service revenues, 2013-2023

SHIFTING CASE MIX

Complex medical volumes threaten to overwhelm inpatient business

Projected inpatient service volumes for adults ages 75+, 2023-2033



SHIFTING SITE MIX

Outpatient a growing proportion of overall care delivery

$50B

Annual estimated loss of hospital revenue due to outpatient shift, industry-wide

1. Major complications or comorbidities (MCC) or complications and comorbidities (CC).

Source: Above All Else we are committed to the care and improvement of human life. *HCA Holdings*. 2013; 2023 Annual Report to Shareholders. *HCA Healthcare*. 2023; Market Scenario Planner. Advisory Board. Accessed August 9, 2024; Beckmann S, Hula N, "Site-of-care shifts: Healthcare's $50B opportunity (advisory.com). Advisory Board. August 8, 2024.

Under pressure, plans and providers proceed with caution

Plans are wary of providers' readiness

Plans are skeptical if providers will make the transformation necessary to deliver on cost and quality outcomes

How providers drive that perception:

- Hesitation to participate in risk-based contracts
- Cultural resistance to change
- Limited population health and data analytics infrastructure

Providers feels unequal burden of responsibility

Providers often feel that health plans make it harder for them to achieve success — and don't invest the same level of effort in executing the contract

How plans drive that perception:

- Delayed or incomplete data delivery
- Added administrative burden on providers without reciprocity
- Lack of operational support for provider partners

Providers want plans that match their investment

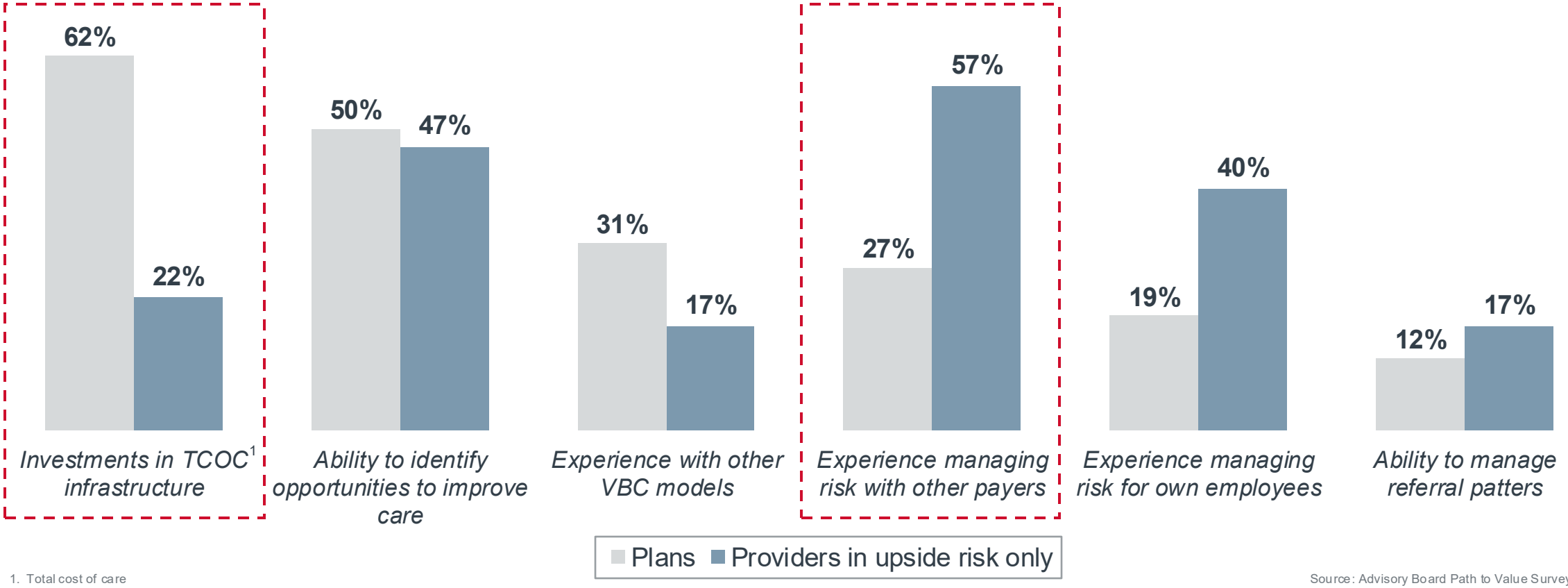
Health plans can demonstrate accountability through shared scorecards

Plan performance metrics	Considerations
❑ Timely data sharing	Maintain consistent, open exchange of data with provider partners • Are providers receiving real-time, actionable data to inform care delivery? • Is the data provided as accurate as possible before the reconciliation period?
❑ Transparent throughout performance period	
❑ Accurate data sharing	
❑ Guidance and support	Support transition to VBC through provider education, infrastructure investments, streamlined documentation
❑ On-time payments	Ensure payments are accurate and timely • Do payments occur consistently at a previously agreed upon cadence? • Are appeals managed efficiently?
❑ Appeals management	

Source: Advisory Board interviews.

Plans want to see tangible investments from providers

What plans look for vs. what providers highlight when negotiating a new risk-based contract



1. Total cost of care

Source: Advisory Board Path to Value Survey 2021.

Where do we go from here?

Payment transformation

Care transformation

Payers – *the drivers*

Drive the industry's shift to VBC by setting cost and quality targets and creating value-based payment arrangements for providers to participate in

Providers – *the implementors*

Implement new care models that focus on providing high-quality care at the lowest possible cost to meet targets set by payers

Purchasers – *the advocates*

Advocate for cost savings for their constituents

Legislators – *the promoters*

Promote the adoption of value-based payment and care delivery models

Partners – *the suppliers*

Supply innovative solutions that aid in both financial and clinical transformations

Patients – *the receivers*

Receive and benefit from lower premiums and more coordinated, individualized care

What a health system in VBC would look like

Case study inclusion criteria

Health system

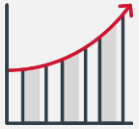
Health system with a dedicated VBC entity

Longevity in VBC

Focused on VBC for more than five years with continued commitment

Broad and deep risk participation

Participation in risk contracts across multiple lines of business



Successful in risk contracts

Generate meaningful cost savings and quality improvement, contributing positively to overall health system financial well-being

8 boxes health systems must check for success in VBC

Governance and vision		Financial transformation			Clinical transformation		
☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8
Executive alignment	Frontline buy-in	Contracting	Payer partnership	Financial visibility	Data analytics and reporting	Population health care model	Network management

Key takeaways

1. **VBC is here to stay.** Many recent developments in the industry at large and specific to VBC have leaders concerned about the future of risk-based models. But for all the potential setbacks, the root causes that created momentum for VBC in the first place have only intensified.
2. **VBC adoption takes 1,000 micro moves.** VBC is an evolving business model, not a one-time project. Building the capabilities necessary to succeed in VBC takes time. Commit to incremental changes and ongoing learning.
3. **Make VBC more than a side hustle.** Health systems exceling in VBC integrated it into core functions and cultural tenets of their institution — operations, innovation, sustainability, academia, their own employees' health. This integration into the organizational fabric ensures longevity and success of VBC initiatives.
4. **Where is VBC on your P&L?** It's easier if you can see VBC on your financial statements. Visibility on the profit and loss (P&L) statement signifies the importance of VBC and signals that it is a line of business requiring investment.
5. **Picking the right partner is more important than making money.** Collaboration and trust between plans and providers are necessary for VBC to work. Don't mistake short-term gains for an effective partnership. The right partnership sets the stage for long-term success for both parties. Choose wisely.
6. **Not everyone wins in VBC**. The competitive landscape of VBC means that not everyone will succeed. Those who don't wait to build their VBC capabilities will be better positioned, while others may find themselves left behind.