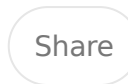
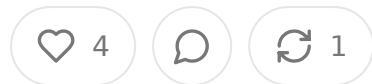


Rethinking Healthcare Economics— Omada Health's Value-Centric Blueprint

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The American healthcare system, as it exists today, is increasingly mismatched with the complex and chronic nature of the diseases it must now manage. Omada Health emerges from this discord not merely as a digital health company, but as an enterprise attempting to reshape both the economic scaffolding and clinical texture of chronic care delivery. Its S-1 filing reveals a blueprint for systemic transformation, anchored in value-based care, continuous digital engagement, and AI-augmented operations. While many digital health organizations have promised to bend the curve of chronic disease, few have laid out, in such detailed operational and contractual terms, how they intend to do so at scale.

The core of Omada's strategy revolves around one foundational idea: the legacy model of episodic reimbursement—where providers are compensated per visit or procedure—is incompatible with the clinical trajectory of chronic disease. Omada's entire operating model, both economically and technologically, has been reverse-engineered from this insight. It positions itself as a between-visit care platform, filling the clinical vacuum that persists between doctor appointments with a combination of continuous digital monitoring, behavioral coaching, and condition-specific interventions. Its model isn't simply to digitize existing care modalities, but to reconstitute them into a new category of longitudinal engagement that thrives under value-based economics.

This is where Omada's contractual structures become particularly instructive. Rather than rely on traditional fee-for-service relationships, Omada aligns its revenue with clinical engagement and outcomes. Contracts with employers, health systems, and health plans are structured around either per-member-per-month models that align

only with a member's engagement, or outcome-contingent pricing frameworks tied to payment for biometric improvements, sustained participation, or reductions in avoidable utilization. This alignment is not incidental—it is baked into the underlying infrastructure of the company's billing engine, member tracking systems, and care team workflows.

These value-based arrangements take several nuanced forms. Some customers enter into Omada through bundled payment constructs, which activate once a member achieves a clinically meaningful threshold of engagement, such as completion of onboard protocols or sustained participation over time. Others enter into hybrid models that combine modest upfront access fees with success-based bonuses. A distinct subset of arrangements uses outcomes-based pricing in its purest form, where reimbursement is pegged to member-level biomarker improvements, including weight loss percentages, reductions in A1C levels, or improvements in blood pressure. For musculoskeletal care, some contracts benchmark payment against the avoidance of high-cost interventions such as imaging or surgical referrals.

What distinguishes these contracts is not only their variety but the way they reflect growing sophistication in payer-side appetite for risk alignment. Omada has structured these contracts with sufficient actuarial transparency and operational instrumentation to allow for real-time monitoring and reporting. This capability is rooted in Omada's proprietary engagement tracking architecture, which tightly integrates biometric data from connected devices with behavioral engagement markers and clinical annotations from care teams. It creates a continuous stream of member-level data that becomes the substrate for outcome measurement, invoice reconciliation, and performance analytics.

Omada's product architecture mirrors its contractual philosophy. It is explicitly designed not around a single condition but rather around the concept of comorbid-aware care. The programs for diabetes, prediabetes, hypertension, musculoskeletal disorders, and GLP-1 support are not standalone verticals; they are composable modules of a unified longitudinal care platform. This modularity allows the company to construct individualized care pathways that account for the interplay between

conditions—a critical capability given the high rates of multimorbidity in the commercially insured population.

For example, a member who enters the platform through a prediabetes risk screen might later be escalated into a combined diabetes and hypertension care track, accompanied by digital coaching and device-based monitoring. The system tracks just clinical signals but behavioral markers such as medication adherence, frequency of food logging, physical activity metrics, and in-app engagement. This data is continuously surfaced to care teams via an internal platform that combines elements of an EHR, customer relationship management system, and real-time telemetry dashboard.

The care teams themselves are not mere adjuncts to the software—they are integral to the delivery model. Omada deploys cross-functional teams composed of coaches, physical therapists, behavioral health specialists, and certified diabetes educators. Each member of the care team is embedded in a software workflow that guides their outreach, documentation, and clinical decision support. Importantly, the care model does not include physicians—an intentional choice that positions Omada not as primary care replacement but as a layer of high-frequency support designed to complement traditional care settings.

This operating model permits an unusual degree of scalability. The S-1 documents describe a system where engagement is not purely reactive but algorithmically triggered. Members receive nudges, content, and outreach based on predictive models that anticipate disengagement, clinical deterioration, or non-adherence. These nudges can take the form of app alerts, asynchronous messaging from care teams, or relevant educational content dynamically surfaced within the platform. The result is a continuous loop of interaction that maintains high touch at low cost—a feat only achievable through software-mediated care orchestration.

This is where the company's technical moat begins to reveal itself. The underlying platform is a synthesis of engagement infrastructure, clinical workflow automation, and machine learning pipelines. Data from connected devices—such as glucose monitors, blood pressure cuffs, and digital scales—is streamed in near real time

fused with user behavior data to create an evolving clinical profile. These profiles serve as the input into the company's proprietary AI stack, which guides both care personalization and operational efficiency.

Omada's data layer is multi-tenant, privacy-preserving, and compliant with HIPAA and other relevant regulations. But it also permits extensive member-level signal extraction for clinical and operational use cases. Members consent to share biometric data, engagement data, and self-reported behavioral data, all of which is used to enhance the personalization of care and refine the AI models that drive engagement prediction and care optimization.

The company's AI infrastructure plays multiple roles. At the edge, it surfaces real-time feedback to members based on biometric signals. At the operational core, it predicts disengagement and care gaps, guiding the outreach of care teams. In analytics, it enables adaptive stratification of risk and performance benchmarking across cohorts, employers, and health plans. The result is a feedback loop in which data drives intervention, intervention drives engagement, and engagement drives clinical outcomes and revenue realization.

These capabilities are not merely aspirational; they are embedded into the way Cigna invoices, reports performance, and renews customer contracts. Its pricing model depends on reliable measurement of engagement and outcomes. Its customer retention depends on continuous demonstration of value. Its go-to-market strategy depends on evidence, not anecdotes. This is why the company has invested heavily in publishing outcomes, pursuing accreditations, and validating its clinical protocols against established guidelines.

As the company seeks to scale, these attributes become increasingly critical. The strategy outlines a vision not merely of growth in covered lives, but of deeper penetration within existing customers. Much of its future growth is predicated not on market capture alone, but on multichannel expansion: adding more programs per customer, increasing enrollment rates within covered populations, and deepening engagement through AI-powered personalization. The care model is deliberately extensible,

designed to accommodate new conditions, new care tracks, and new modalities without fracturing the core engagement architecture.

What is especially notable is the company's discipline in managing the margin structure of these programs. While still operating at a net loss, Omada has demonstrated increasing efficiency in its cost of delivery. AI-driven triage and task routing have reduced the burden on care teams. Automation of onboarding, engagement workflows, and outcomes reporting have compressed the cost of acquiring and servicing each member. These efficiencies accrue directly to gross margin improvement—a critical metric for any digital health company attempting to prove the scalability of a high-touch model.

As the digital health market matures, the true challenge is no longer proving clinical efficacy in isolation. It is demonstrating the operational viability of value-based models at scale. Omada Health's S-1 filing is not just a registration document—it is a declaration of architectural intent. It signals a deliberate pivot from episodic, visit-centric care to an always-on, data-driven model of longitudinal engagement. It reimagines reimbursement, care delivery, and patient experience not as discrete but as interlocking components of a unified value engine.

Between-Visit Care as a Platform: The Engineered Delivery Model Behind Omada Health

The architecture of Omada Health's business is built to operationalize a concept traditional providers cannot support: continuous, precision-aligned care delivery between scheduled appointments. The company has constructed a care model not as an appendage to the provider system but as a parallel infrastructure capable of absorbing large volumes of risk-based contracts, while maintaining fidelity to individual-level outcomes. This system, which Omada terms "Compassionate Intelligence," operates as both a care philosophy and a software framework. It unites human care teams with a machine-learning backbone, delivering modular, condi-

specific programs that are continuously adapted to a member's behavior, physiology, and clinical progression.

At the heart of this design is Omada's proprietary care team platform, a system that resembles an electronic health record but functions more like a care delivery operating system. It handles everything from triaging incoming biometric data to managing asynchronous member communication, assigning follow-up tasks to care teams, and triggering escalation protocols when signs of clinical deterioration emerge. While many healthcare organizations tout their use of AI, Omada has embedded it within the operational pulse of the company, integrating machine intelligence directly into workflow logic rather than layering it on top as a separate analytics module.

This integration allows for an unusually fluid interaction between clinical staff and data. Care coaches receive suggestions for outreach that are dynamically prioritized based on predicted impact. AI-driven stratification identifies which members are at risk of disengagement or clinical decompensation, enabling the platform to deliver personalized nudges, initiate new care protocols, or adjust care cadence automatically. The benefit is not simply increased efficiency—it is a delivery model where care can be tuned in near-real time, at scale, to the evolving needs of each individual.

The company's ability to deliver this level of customization stems from its expansive data graph, which fuses biometric telemetry, app engagement data, behavioral insights, medication adherence reports, and care team annotations. These data are not merely warehoused; they are continuously parsed and interpreted via a stack of machine learning models that refine over time with feedback loops from outcomes data. This permits Omada to support engagement-based reimbursement structures that would be infeasible under a more static or episodic model.

What is particularly instructive is how this infrastructure enables contract execution. Unlike traditional health systems, which must rely on retrospective claims analysis to assess the value delivered, Omada can produce live performance dashboards for payers. Employers, health plans, and pharmacy benefit managers are able to view in near real time, the enrollment metrics, engagement trends, and early outcome signals for their covered populations. This transparency undergirds Omada's pricing

flexibility, allowing it to offer risk-based contracting models with confidence and precision.

In fact, the diversity of value-based contracts Omada supports is partly a function of its real-time data instrumentation. Some customers pay only when a member logs on the platform and completes onboarding milestones. Others are billed monthly per engaged member, but only after a sustained interaction threshold is reached—often defined by weight tracking frequency, lesson completion, or biometric monitoring adherence. Still others trigger payments only upon outcome realization, such as weight loss milestones or clinical improvements in A1C or blood pressure.

This layered pricing flexibility enables Omada to work with a variety of stakeholders. Employers looking for ROI on wellness investments can contract under pure outcomes models. Health plans seeking predictable costs may favor PMPM contracts with escalating tiers based on engagement or outcomes thresholds. PBMs that operate as channel partners may act as resellers, bundling Omada into broader medication management offerings. Omada's infrastructure supports all these models simultaneously, tracking eligibility, engagement, outcomes, and billing across multiple contract archetypes.

The scalability of this approach has already been tested in the market. Omada's customer base exceeds two thousand organizations, including major employers, state health systems, and leading PBMs. Importantly, many of these customers have adopted multiple Omada programs—diabetes prevention, hypertension management, musculoskeletal care, GLP-1 therapy support—rather than engaging only a single vertical. This bundling reflects not only sales strategy but care philosophy. Omada programs are designed to be comorbidity-aware, allowing members to transition fluidly between modules without disruption or duplicate onboarding.

For example, a member who begins in the diabetes prevention program may later present with blood pressure dysregulation or chronic pain. The system identifies these issues and dynamically extends the care plan to include modules from the hypertension or MSK care tracks. The same care coach may remain involved, supported by specialized consultations and content customized to the new clinical domain. The goal is

continuity, not just across episodes of care but across conditions and phases of disease.

This model is distinctly at odds with the traditional, fragmented approach to chronic care. Health systems tend to silo specialties, create redundant intake processes, and rarely share behavioral data across providers. Omada's model fuses these silos into a single longitudinal thread. The member does not see a patchwork of programs—see a single, coherent experience that adapts as their condition evolves.

This coherence is critical for behavior change, which is ultimately what Omada's model achieves. While the company reports clinical outcomes like weight loss, A1C reduction, and improved blood pressure control, the core mechanism of action is behavioral modification supported by structured accountability, digital tracking, and personalized feedback. That mechanism requires a high-functioning engagement engine—one that Omada has refined to operate at population scale.

Omada's engagement engine begins with targeted outreach, typically triggered when a member is identified as eligible by a health plan or employer. Outreach is not generic; it is shaped by member-specific risk scores, employer benefit design, and clinical eligibility. Upon enrollment, the system initiates a structured onboarding sequence: connected device setup, coach introduction, goal setting—which is algorithmically adjusted for condition type and comorbidity profile. Engagement strategies vary from high-frequency digital nudges to human-led motivational interviewing, depending on the predicted responsiveness of the member segment.

Once active, members are nudged daily or weekly depending on their profile, with content, challenges, or reminders delivered through mobile interfaces. These touchpoints are informed by predictive analytics that determine what type of message, timing, and tone are most likely to prompt a response. For disengaged users, escalation paths are triggered that include coach outreach or, in some cases, clinical escalation for signs of worsening condition.

Critically, these interventions are not random—they are prioritized through real-time ranking of impact likelihood. A care coach might see a task list organized not by

chronological order but by expected value of intervention, enabling each hour of coach time to be maximally efficient. This sort of micro-optimization is the hallmark of a platform that is both AI-enabled and outcomes-accountable.

On the backend, these engagement markers also feed into the company's internal performance management system. Omada tracks not only individual member outcomes, but also coach-level effectiveness, program-level ROI, and customer-level performance benchmarks. This enables rapid iteration of content, outreach strategies, and care workflows. Underperforming cohorts can be identified and re-engaged; strategies can be A/B tested in production; and performance can be visualized for customers with precision.

The result is a virtuous cycle: better engagement improves outcomes; better outcomes validate the model; validation enables deeper risk-based contracts; deeper contracts fuel growth and reinvestment into platform refinement. Few digital health companies have closed this loop with the same degree of operational rigor.

What emerges from all of this is a care delivery platform that is not merely digital in its interface but engineered in its structure. It is a system where every layer—from contract design to care protocol to member nudge—is part of a tightly coupled ecosystem calibrated for value-based care. And in an industry where most value-based rhetoric is undermined by infrastructure incapable of supporting it, Omada's system stands apart in its completeness.

Executing at Scale—Omada's Performance, Strategic Leverage, and the Path to Structural Healthcare Change

When evaluating a digital health company that positions itself as a partner in value-based care, the most critical question is not whether the model is theoretically sound. The question is whether the company has executed against that model consistently at scale, and with economically measurable results. In this respect, Omada Health presents one of the most comprehensive and revealing data sets of any pre-IPO

healthcare organization in the digital chronic care space. Its S-1 filing not only discloses customer volume and revenue metrics, but also articulates the longitudinal clinical and operational indicators that underpin its value proposition.

Since inception, Omada has served over one million members through more than 2,000 enterprise customers. While many digital therapeutics platforms have struggled with user attrition and short engagement lifecycles, Omada presents a significantly more durable profile. Over half of its members remain engaged with the platform full year after enrollment. By the second year, nearly the same number continues to log in, record health metrics, and communicate with their care teams. These are not superficial app interactions—they include high-value engagements like blood pressure monitoring, weigh-ins through connected scales, and blood glucose tracking through CGMs and BGM devices.

This level of sustained engagement is not incidental; it is the result of deliberate product design and a care model built for longitudinal relevance. Members are not treated as passive recipients of content but as active participants in a continuous, adaptive clinical journey. The result is behavior change that is trackable, reinforceable, and translatable into biometric improvements—improvements that Omada explicitly prices into its contracts.

The durability of engagement also translates into financial leverage. While Omada still reports net losses, these losses are narrowing. Revenue has grown significantly year over year, but the more important indicator is the company's expanding gross margin. The automation of triage workflows, AI-driven engagement routing, and scalable onboarding processes have lowered the variable cost per enrolled member. Unlike health systems, which carry significant fixed overhead for each new patient panel, Omada's model allows for non-linear margin scaling. As the number of enrolled members grows, the marginal cost of servicing each new individual declines, while contract revenue per member remains relatively constant or improves with multi-condition bundling.

This operational leverage is key to the company's broader economic theory. Omada is not betting on a singular disease area, nor on a narrow vertical of payer interest.

constructing a care infrastructure that can support multiple chronic conditions a diverse mix of contracts—employers, fully insured health plans, self-funded ER plans, PBMs, and health systems. The infrastructure is sufficiently abstracted from any single reimbursement model to allow flexibility in pricing and risk sharing. ' abstraction is a strategic asset; it gives Omada the ability to absorb macro-level shifts in how payers are funding chronic care.

Indeed, the company has already diversified its channels. While it began with direct employer sales, it now operates embedded within PBM networks, through benefit consultants, and increasingly within the ecosystem of health systems that seek to outsource between-visit engagement. This multi-channel resilience positions the company not only as a standalone provider but as an infrastructure partner—a connective layer that can be plugged into existing delivery systems and payer architectures without redundancy.

What's notable is that Omada has resisted the temptation to integrate deeply with traditional physician-led primary care. Its model is collaborative, not substitutive. This decision reflects both strategic clarity and an understanding of regulatory constraints. By avoiding direct provision of medical diagnosis or treatment—roles reserved for physicians under most state law—Omada maintains a clear scope of practice while still driving meaningful health behavior change. It serves as an amplifier to primary care, not a competitor.

For health systems, this is perhaps the most valuable lesson. The future of chronic care may not lie in owning every facet of the patient relationship, but in orchestrating a network of collaborators that operate at different frequencies and intensities of engagement. Omada represents the high-frequency, low-acuity layer—a digital scaffolding that wraps around traditional care to reinforce adherence, drive accountability, and surface deterioration signals before they become catastrophic cost events.

Health systems looking to replicate or integrate Omada's model must start by rethinking their own operational tempos. The cadence of hospital-anchored care is episodic, designed around intake, intervention, and discharge. Omada's tempo is ambient, continuous, and tuned to early signals. The operational systems needed

support that cadence—particularly in triage, nudging, device data ingestion, and driven care routing—are fundamentally different from the systems used to manage episodic care. And they are non-trivial to build.

Omada's moat, in this sense, is not just technical—it is temporal. It has built not a technology stack, but an institutional rhythm that allows for the monitoring and adjustment of care plans on a daily or weekly basis, rather than quarterly or annually. This cadence is sustained not by brute clinical staffing, but by algorithmically prioritized workflows that ensure human touch is applied where it is most impactful. The result is a lean clinical labor model that still delivers personalized care—a model that is particularly compelling in a healthcare labor market marked by burnout and scarcity.

But this model is only as good as its data—and here, too, Omada has constructed a defensible position. The company's ability to ingest, process, and learn from continuous biometric and engagement data has allowed it to build predictive models with a degree of granularity not available to traditional providers. These models are not black boxes. They feed into care recommendations, nudge sequences, and performance reporting dashboards that are accessible to care teams and customers alike. This transparency is a strategic differentiator, particularly in an era where data is often viewed with suspicion by regulators and clinicians.

The member data fueling these models is shared through explicit consent flows. Members authorize the use of their biometric, engagement, and self-reported data for purposes of care delivery, personalization, and operational improvement. Importantly, the data is not sold to third parties, nor is it used for marketing outside the care experience. This trust architecture—clear permissions, clear boundaries, and demonstrable value in exchange for data—underpins the high engagement and low attrition that the company reports.

For those looking ahead to Omada's next phase, the question is whether this model can continue to scale, both economically and clinically. The evidence from the S- suggests that it can. Member acquisition has grown, multicontract customers are becoming the norm, and engagement durability remains high. If the company can

continue to expand into more fully insured populations, increase enrollment with existing covered lives, and continue refining its AI-enabled efficiency gains, the economics become increasingly favorable.

But perhaps the larger implication is not what Omada can do, but what others must do in response. Health systems that have historically viewed chronic care as an unprofitable service line must now contend with the possibility that value-based enabled models can deliver better outcomes at lower cost—and do so without the infrastructure of bricks-and-mortar. Payers that have struggled to reduce medical spend on chronic populations must now ask whether outsourcing to platforms like Omada offers a better return than trying to drive adherence through claims-based incentives alone.

The emergence of Omada marks a pivot point for the industry. It shows that care delivery can be both human and algorithmic, both compassionate and efficient, both high-touch and high-scale. It demonstrates that value-based care need not be a regulatory imposition or a buzzword in a benefits RFP—but a structural design principle that guides how care is delivered, how contracts are written, and how software is built.

In this, Omada's S-1 is more than a prelude to public listing. It is a statement of contract between patients, payers, and platforms. A contract that does not begin and end with the visit—but lives in the space between. And that space, if designed well, may be where the future of care is made.



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