Evolent Health Annual Report 2018

Form 10-K (NYSE:EVH)

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2017

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____

Commission File Number: 001-37415

Evolent Health, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**32-0454912**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
800 N. Glebe Road, Suite 500, Arlington, Virginia	**22203**
(Address of principal executive offices)	**(Zip Code)**

(571) 389-6000

Registrant's telephone number, including area code

Securities registered pursuant to section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Class A Common Stock, par value $0.01 per share	New York Stock Exchange

Securities registered pursuant to section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined by Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 12 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13 (a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (based on the closing price of the shares on the New York Stock Exchange on such date) as of the last business day of the registrant's most recently completed second fiscal quarter was $1,191.7 million.

As of February 23, 2018, there were 74,784,529 shares of the registrant's Class A common stock outstanding and 2,653,544 shares of the registrant's Class B common stock outstanding.

Documents Incorporated by Reference

Selected portions of the Proxy Statement for the Annual Meeting of Shareholders, scheduled for June 13, 2018, have been incorporated by reference into Part III of this Form 10-K to the extent stated herein. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days of the registrant's fiscal year ended December 31, 2017.

Evolent Health, Inc.
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Explanatory Note

In this Annual Report on 10-K, unless the context otherwise requires, “Evolent,” the “Company,” “we,” “our” and “us” refer to (1) prior to the completion of the Offering Reorganization described in “Part II - Item 8. Financial Statements and Supplementary Data - Note 4”, Evolent Health Holdings, Inc., our predecessor, (including its operating subsidiary, Evolent Health LLC), and (2) after giving effect to such reorganization, Evolent Health, Inc. and its consolidated subsidiaries. Evolent Health LLC, a subsidiary of Evolent Health, Inc. through which we conduct our operations, has owned all of our operating assets and substantially all of our business since inception. Evolent Health, Inc. is a holding company and its principal asset is all of the Class A common units of Evolent Health LLC. As described below under “Part II - Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations - Results of Operations,” the financial statements of Evolent Health, Inc. for the year ended December 31, 2015, does not reflect a complete view of the operational results for that period as follows:

- Evolent Health, Inc.'s results for 2015 reflect (i) the investment of Evolent Health, Inc.'s predecessor in its equity method investee, Evolent Health LLC, for the period from January 1, 2015, through June 3, 2015, and (ii) the consolidated results of Evolent Health LLC from the time of the Offering Reorganization, or June 4, 2015, through December 31, 2015.

For more information about the Offering Reorganization, refer to “Part II - Item 8. Financial Statements and Supplementary Data - Note 4.”

As used in this Annual Report on Form 10-K:

- “2021 Notes” means the $125.0 million aggregate principal amount 2.00% Convertible Senior Notes due 2021, issued by Evolent Health, Inc. in December 2016;
- “ACA” means the Patient Protection and Affordable Care Act;
- “Accordion” means Accordion Health, Inc.;
- “accountable care organizations,” or “ACOs,” means organizations of groups of doctors, hospitals and other health care providers which have come together voluntarily to provide coordinated care to their Medicare patients;
- “Aldera” means Aldera Holdings, Inc.;
- “ASU” means Accounting Standards Update;
- “capitated arrangements” means health care payment arrangements whereby providers are paid a fixed amount of money per patient during a given period of time rather than on a per-service or per-procedure basis;
- “CMS” means the Centers for Medicare and Medicaid Services;
- “DGCL” means General Corporation Law of the State of Delaware;
- “EMR” means electronic medical records;
- “Evolent Health Holdings” means Evolent Health Holdings, Inc., the predecessor to Evolent Health, Inc.;
- “Exchange Act” means the Securities Exchange Act of 1934, as amended;
- “FASB” means the Financial Accounting Standards Board;
- “FFS” means fee-for-service;
- “founders” means the Advisory Board Company (“The Advisory Board”), and the University of Pittsburgh Medical Center (“UPMC”);
- “FTC” means the United States Federal Trade Commission;
- “GAAP” means United States of America generally accepted accounting principles;
- “GPAC” means Georgia Physicians for Accountable Care, LLC;
- “health insurance exchanges” means organizations that provide a marketplace for individuals to purchase standardized and government regulated health insurance policies;
- “HIPAA” means The Health Insurance Portability and Accountability Act;
- “HITECH Act” means The Health Information Technology for Economic and Clinical Health Act;
- “Indenture” means the indenture between Evolent Health, Inc. and U.S. Bank National Association, as trustee, related to the 2.00% convertible senior notes due 2021, dated as of December 5, 2016;
- “IPO” means our initial public offering as described in “Part II – Item 8. Financial Statements and Supplementary Data - Note 1;”
- “NMHC” means New Mexico Health Connections;
- “NOL” means net operating loss;
- “Note” means notes to consolidated financial statements presented in “Part II – Item 8. Financial Statements and Supplementary Data;”
- “NYSE” means the New York Stock Exchange;
- “Offering Reorganization” means the reorganization undertaken in 2015 prior to our IPO. See “Part II – Item 8. Financial Statements and Supplementary Data - Note 4” for further details of the Offering Reorganization;
- “partners” means our customers, unless we indicate otherwise or the context otherwise implies;
- “Passport” means University Health Care, Inc. d./b/a/ Passport Health Plan;

- “pharmacy benefit management,” or “PBM,” means the administration of prescription drug programs, including developing and maintaining a list of medications that are approved to be prescribed, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers and processing prescription drug claim payments;
- “PMPM” means per member per month;
- “population health” means an approach to health care that seeks to improve the health of an entire human population;
- “Private Placement” means Evolent Health, Inc.’s offering of the $125.0 million aggregate principal amount 2.00% Convertible Senior Notes due 2021, to qualified institutional buyers within the meaning of Rule 144A under the Securities Act of 1933, as amended;
- “Ptolemy Capital” means Ptolemy Capital, LLC;
- “RAF” means risk-adjustment factor;
- “RSUs” means restricted stock units;
- “SEC” means the Securities and Exchange Commission;
- “Securities Act” means the Securities Act of 1933, as amended;
- “Series B Reorganization” means our reorganization undertaken in 2013 in connection with a round of equity financing;
- “third-party administration,” or “TPA,” means the processing of insurance claims or the administration of certain aspects of employee benefit plans for a separate entity;
- “True Health” means True Health New Mexico, Inc., a wholly-owned subsidiary of Evolent Health, Inc.;
- “TPG” means TPG Global, LLC and its affiliates including one or both of TPG Growth II BDH, LP and TPG Eagle Holdings, L.P.;
- “TRA” means the Income Tax Receivables Agreement. See “Part II – Item 8. Financial Statements and Supplementary Data - Note 12” for further details of the Tax Receivables Agreement;
- “UR” means utilization review;
- “Valence Health” means Valence Health, Inc., excluding Cicerone Health Solutions, Inc.;
- “value-based care” means a health care management strategy that is focused on high-quality and cost-effective care with the goals of promoting a healthy lifestyle, enhancing the patient experience and reducing preventable hospital admissions and emergency visits; and
- “Vestica” means Vestica Healthcare, LLC.

FORWARD-LOOKING STATEMENTS - CAUTIONARY LANGUAGE

Certain statements made in this report and in other written or oral statements made by us or on our behalf are “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995 (“PSLRA”). A forward-looking statement is a statement that is not a historical fact and, without limitation, includes any statement that may predict, forecast, indicate or imply future results, performance or achievements, and may contain words like: “believe,” “anticipate,” “expect,” “estimate,” “aim,” “predict,” “potential,” “continue,” “plan,” “project,” “will,” “should,” “shall,” “may,” “might” and other words or phrases with similar meaning in connection with a discussion of future operating or financial performance. In particular, these include statements relating to future actions, trends in our businesses, prospective services, future performance or financial results and the outcome of contingencies, such as legal proceedings. We claim the protection afforded by the safe harbor for forward-looking statements provided by the PSLRA.

These statements are only predictions based on our current expectations and projections about future events. Forward-looking statements involve risks and uncertainties that may cause actual results, level of activity, performance or achievements to differ materially from the results contained in the forward-looking statements. Risks and uncertainties that may cause actual results to vary materially, some of which are described within the forward-looking statements, include, among others:

- the structural change in the market for health care in the United States;
- uncertainty in the health care regulatory framework;
- uncertainty in the public exchange market;
- the uncertain impact of CMS waivers to Medicaid rules;
- the uncertain impact the results of the 2018 congressional, state and local elections, as well as subsequent elections, may have on health care laws and regulations;
- our ability to effectively manage our growth;
- the significant portion of revenue we derive from our largest partners, and the potential loss, termination or renegotiation of customer contracts;
- our ability to offer new and innovative products and services;
- risks related to completed and future acquisitions, investments and alliances, including the acquisition of assets from NMHC and the acquisitions of Valence Health and Aldera, which may be difficult to integrate, divert management resources, result in unanticipated costs or dilute our stockholders;
- certain risks and uncertainties associated with the acquisition of assets from NMHC and the acquisition of Valence Health, including future revenues may be less than expected, the timing and extent of new lives expected to come onto the platform may not occur as expected and the expected results of Evolent may not be impacted as anticipated;

- the growth and success of our partners, which is difficult to predict and is subject to factors outside of our control, including premium pricing reductions, selection bias in at-risk membership and the ability to control and, if necessary, reduce health care costs, particularly in New Mexico;
- our ability to attract new partners;
- the increasing number of risk-sharing arrangements we enter into with our partners;
- our ability to recover the significant upfront costs in our partner relationships;
- our ability to estimate the size of our target market;
- our ability to maintain and enhance our reputation and brand recognition;
- consolidation in the health care industry;
- competition which could limit our ability to maintain or expand market share within our industry;
- risks related to governmental payor audits and actions, including whistleblower claims;
- our ability to partner with providers due to exclusivity provisions in our contracts;
- restrictions and penalties as a result of privacy and data protection laws;
- adequate protection of our intellectual property, including trademarks;
- any alleged infringement, misappropriation or violation of third-party proprietary rights;
- our use of “open source” software;
- our ability to protect the confidentiality of our trade secrets, know-how and other proprietary information;
- our reliance on third parties and licensed technologies;
- our ability to use, disclose, de-identify or license data and to integrate third-party technologies;
- data loss or corruption due to failures or errors in our systems and service disruptions at our data centers;
- online security risks and breaches or failures of our security measures;
- our reliance on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing services to our users;
- our reliance on third-party vendors to host and maintain our technology platform;
- our ability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits or maintain cost effective provider agreements;
- the risk of a significant reduction in the enrollment in our health plan;
- our dependency on our key personnel, and our ability to attract, hire, integrate and retain key personnel;
- the risk of potential future goodwill impairment on our results of operations;
- our indebtedness and our ability to obtain additional financing;
- our ability to achieve profitability in the future;
- the requirements of being a public company;
- our adjusted results may not be representative of our future performance;
- the risk of potential future litigation;
- our holding company structure and dependence on distributions from Evolent Health LLC;
- our obligations to make payments to certain of our pre-IPO investors for certain tax benefits we may claim in the future;
- our ability to utilize benefits under the tax receivables agreement described herein;
- our ability to realize all or a portion of the tax benefits that we currently expect to result from past and future exchanges of Class B common units of Evolent Health LLC for our Class A common stock, and to utilize certain tax attributes of Evolent Health Holdings and an affiliate of TPG;
- distributions that Evolent Health LLC will be required to make to us and to the other members of Evolent Health LLC;
- our obligations to make payments under the tax receivables agreement that may be accelerated or may exceed the tax benefits we realize;
- different interests among our pre-IPO investors, or between us and our pre-IPO investors;
- the terms of agreements between us and certain of our pre-IPO investors;
- the potential volatility of our Class A common stock price;
- the potential decline of our Class A common stock price if a substantial number of shares are sold or become available for sale or if a large number of Class B common units are exchanged for shares of Class A common stock;
- provisions in our second amended and restated certificate of incorporation and second amended and restated by-laws and provisions of Delaware law that discourage or prevent strategic transactions, including a takeover of us;
- the ability of certain of our investors to compete with us without restrictions;
- provisions in our second amended and restated certificate of incorporation which could limit our stockholders’ ability to obtain a favorable judicial forum for disputes with us or our directors, officers or employees;
- our intention not to pay cash dividends on our Class A common stock;
- our ability to remediate the material weakness in our internal control over financial reporting;
- our expectations regarding the additional management attention and costs that will be required as we transition from an “emerging growth company” to a “large accelerated filer”; and
- our lack of public company operating experience.

The risks included here are not exhaustive. Although we believe the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, level of activity, performance or achievements. More information on potential factors

that could affect our businesses and financial performance is included in “Forward Looking Statements - Cautionary Language,” “Risk Factors” and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” or similarly captioned sections of this Annual Report and the other period and current filings we make from time to time with the SEC. Moreover, we operate in a rapidly changing and competitive environment. New risk factors emerge from time to time, and it is not possible for management to predict all such risk factors.

Further, it is not possible to assess the effect of all risk factors on our businesses or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements. Given these risks and uncertainties, investors should not place undue reliance on forward-looking statements as a prediction of actual results. In addition, we disclaim any obligation to update any forward-looking statements to reflect events or circumstances that occur after the date of this report.

Market Data and Industry Forecasts and Projections

We use market data and industry forecasts and projections throughout this Annual Report on Form 10-K, and in particular in “Part I - Item 1. Business.” We have obtained the market data from certain publicly available sources of information, including publicly available independent industry publications and other third-party sources. Unless otherwise indicated, statements in this Annual Report on Form 10-K concerning our industry and the markets in which we operate, including our general expectations and competitive position, business opportunity and market size, growth and share, are based on information from independent industry organizations and other third-party sources (including industry publications, surveys and forecasts), data from our internal research and management estimates. Forecasts are based on industry surveys and the preparer’s expertise in the industry and there is no assurance that any of the forecasted amounts will be achieved. We believe the data that third parties have compiled is reliable, but we have not independently verified the accuracy of this information (other than information provided by our affiliates). Any forecasts are based on data (including third-party data), models and experience of various professionals and are based on various assumptions, all of which are subject to change without notice. While we are not aware of any misstatements regarding the industry data presented herein, forecasts, assumptions, expectations, beliefs, estimates and projections involve risks and uncertainties and are subject to change based on various factors, including those described under the heading “Forward-Looking Statements - Cautionary Language” and in “Part I - Item IA. Risk Factors.”

PART I

Item 1. Business

Company Overview

We are a market leader in the new era of health care delivery and payment, in which leading health systems and physician organizations, which we refer to as providers, are taking on increasing clinical and financial responsibility for the populations they serve. Our purpose-built platform, powered by our technology, proprietary processes and integrated services, enables providers to migrate their economic orientation from FFS reimbursement to payment models that reward high-quality and cost-effective care, or value-based payment models. By partnering with providers to accelerate their path to value-based care, we enable our provider partners to expand their market opportunity, diversify their revenue streams, grow market share and improve the quality of the care they provide.

We believe we are pioneers in enabling health systems to succeed in value-based payment models. We were founded in 2011 by members of our management team, UPMC, an integrated delivery system based in Pittsburgh, Pennsylvania, and The Advisory Board, to enable providers to pursue a value-based business model and evolve their competitive position and market opportunity. We consider value-based care to be the necessary convergence of health care payment and delivery. We believe the pace of this convergence is accelerating, driven by price pressure in traditional FFS health care, a market environment that is incentivizing value-based care models and innovation in data and technology. We believe providers are positioned to lead this transition to value-based care because of their control over large portions of health care delivery costs, their primary position with consumers and their strong local brand.

Today, increasing numbers of providers are adopting value-based strategies, including contracting for capitated arrangements with existing insurance companies, governmental payers or large self-funded employers and managing their own captive health plans. Through value-based care, providers are in the early stages of transforming their role in health care as they attempt to defend their existing position and capture a greater portion of the more than two trillion dollars in annual health insurance expenditures. While there is not a universally agreed-upon definition of value-based care, we estimate that approximately 10% of health care payments were paid through value-based care programs as of June 2014, including through models created by systems like UPMC, Kaiser Permanente and Intermountain Healthcare, it is estimated that this number will grow to over approximately 50% by 2020. There were over 140 provider-owned health plans as of 2016 and this number continues to grow. The number of ACOs constructed to manage capitated or value-based arrangements with existing insurance companies or government payers grew to 838 as of January 2016.

We believe the transformation of the provider business model will require a set of core capabilities, including the ability to aggregate and understand disparate clinical and financial data, standardize and integrate technology into care processes, manage population health and build a financial and administrative infrastructure that capitalizes on the clinical and financial value it delivers. We provide an end-to-end, built-for-purpose, technology-enabled services platform for providers to transition their organization and business model to succeed in value-based payment models. In certain instances, we participate alongside our partners in risk-sharing arrangements whereby we share in a portion of the upside and downside performance of the value strategy. The core elements of our services platform include:

- ***Integrated technology, proprietary process and financial and administrative services model*** that enables the delivery of a high-performing population health organization, an aligned clinical delivery network to provide high-quality, coordinated care and an efficient administrative infrastructure to administer value-based care payment relationships.
  - ***Identifi®, our proprietary technology,*** delivers the data aggregation and stratification, proven value-based care content, EMR optimization and proprietary applications that allow providers to standardize the delivery of care and enable clinical and financial analytics.
  - ***Our complementary value-based operations*** are empowered and supported by Identifi®. Other elements include: (1) an aligned clinical delivery network to provide improved, coordinated care, (2) a high-performing population health organization that drives clinical outcomes and (3) integration of cost management solutions including PBM and patient risk scoring.
  - ***Our comprehensive financial and administrative management services*** enable providers to operate, manage and capitalize on a variety of value-based payment arrangements
- ***A single point of integration between payers and the provider community*** enables us to provide an indispensable single point of integration between a diverse set of payers that becomes more valuable over time as our services platform becomes the standard for value-based care contracting and operations.

In October 2016, we acquired Valence Health. Valence Health, based in Chicago, Illinois, was founded in 1996 and provides value- based administration, population health and advisory services with a particular focus on the Medicaid and pediatric markets. We believe that the acquisition of Valence Health is highly complementary to Evolent's business and brings a number of strategic benefits including: (1) enhanced capabilities in value-based care administration and claims processing; (2) increased presence and experience in the Medicaid market and (3) additional scale to our platform in the form of approximately 1.0 million incremental lives under

operating agreements. On January 2, 2018, we completed the acquisition of assets related to NMHC's commercial business. Following the completion of the transaction, we contributed the assets of NMHC's commercial business to True Health, a wholly-owned subsidiary of the Company. True Health is a commercial health plan we operate in New Mexico that focuses on small and large businesses. We expect to be able to leverage our platform to support a value-based provider-centric model of care in the state.

We believe our business model provides strong visibility and aligns our partners' incentives with our own. Through our financial and administrative management services, we capture value through a variety of value-based payment arrangements and, in certain circumstances, participate alongside our partners in risk-sharing arrangements. A large portion of our revenue is derived from our multi-year contracts, which are linked to the number of members that our partners are managing under a value-based care arrangement. This variable pricing model depends on the population being served as well as the number of services and technology applications that our partners utilize to advance their value-based care strategies and the number of members they are able to attract over time. We expect to grow with current partners as they increase membership in their existing value-based programs, through expanding the number of services we provide to our existing partners, by adding new partners and by capturing value through upside risk-sharing arrangements.

We believe we are in the early stages of capitalizing on these aligned operating partnerships. We believe our health system partners' current value-based care arrangements represent a small portion of the health system's total revenue each year. We believe the proportion of value-based care related revenues to total health system revenues will continue to grow, driven by continued price pressure in FFS, new government payment programs, growth in consumer-focused insurance programs, such as Medicare Advantage and managed Medicaid, and innovation in data and technology. Our business model benefits from scale, as we leverage our purpose-built technology-enabled services platform and centralized resources in conjunction with the growth of our partners' membership base. These resources include our network development capabilities, health plan administrative services, PBM administration, technology development, clinical program development and data analytics and network development. While our absolute investment in our centralized resources and technologies will increase over time, we expect it will decrease as a percentage of revenue as we are able to scale this investment across a broader group of partners.

We manage our operations and allocate resources as a single reportable segment; however, we anticipate that we will report the results of True Health as a new reportable segment effective first quarter of 2018. See "Part II - Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Part II - Item 8 - Financial Statements and Supplementary Data" of this Annual Report on Form 10-K regarding revenue, profit and total assets of our single operating segment. All of our revenue is recognized in the United States and all of our long-lived assets are located in the United States.

Our Market Opportunity

For 2017, health care spending in the United States was projected to be more than $3.4 trillion. We believe that for the U.S. health care system to shift to a value-based care delivery model, providers must be an empowered part of the solution. Our comprehensive technology and services platform enables providers to capitalize on this transition, which we believe will position us to be at the forefront of the transformation to value-based care.

We believe our total market opportunity for our services platform is over $10.0 billion today based on health insurance expenditures, the total percentage of payments providers receive under value-based contracting, the size of the provider-sponsored health plan market and the fees we believe we can charge. We believe this opportunity will grow to over $45.0 billion by 2020 driven by health insurance expenditures increasing from approximately $2.1 trillion in 2013 to approximately $3.2 trillion in 2020, the total percentage of payments providers receive under value-based care models growing from 10% as of June 2014 to over 50% in 2020, and the provider-sponsored health plan market representing 15% of total health plan membership in 2020.

Our Solution

We provide an end-to-end, built-for-purpose, technology-enabled services platform for providers to succeed in value-based payment models.

Supporting Multiple Value-Based Care Models

Our services platform was built to support a diverse set of provider value-based care strategies. It provides the core technology and services necessary for all models pursued by providers.

Providers partner with us on at least one of three types of value-based contracting models, with most supporting at least the Direct to Employer model and one additional type of contracting arrangement.

- *Direct to Employer:* Manage costs for self-funded employers including a health system's own employees
- *Payer contracts:* Value-based contracts with third-party payors (including commercial insurers and the government) that include a full spectrum of risk for pay for performance through full capitation arrangements