Evolent Health Annual Report 2019

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, 2018

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 in Rule 405 of the Securities Act. Yes ☒ No ☐
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 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 every Interactive Data File required to be submitted 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 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 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 $1,451.6 million.
As of February 25, 2019, there were 79,375,842 shares of the registrant's Class A common stock outstanding and 3,190,301 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 11, 2019, 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, 2018.

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 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 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;
- “2025 Notes” means the $172.5 million aggregate principal amount 1.50% Convertible Senior Notes due 2025, issued by Evolent Health, Inc. in October 2018;
- “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;
- “IPO” means our initial public offering of 13.2 million shares of our Class A common stock at a public offering price of $17.00 per share in June 2015;
- “New Century Health” means NCIS Holdings, Inc.;
- “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 where our predecessor, Evolent Health Holdings, Inc. merged with and into Evolent Health, Inc.;
- “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;
- “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 significant portion of revenue we derive from our largest partners, and the potential loss, termination or renegotiation of customer contracts;
- uncertainty relating to expected future revenues from and our relationship with our largest customer, Passport, including as a result of ongoing litigation pertaining to rate adjustments and Passport’s ability to remain solvent, which among other things could result in significantly reduced fees or a significant customer loss in 2019;
- the structural change in the market for health care in the United States;
- uncertainty in the health care regulatory framework, including the potential impact of policy changes;
- uncertainty in the public exchange market;
- the uncertain impact of CMS waivers to Medicaid rules and changes in membership and rates;
- the uncertain impact the results of elections may have on health care laws and regulations;
- our ability to effectively manage our growth, maintain an efficient cost structure;
- our ability to offer new and innovative products and services;
- risks related to completed and future acquisitions, investments, alliances and joint ventures, including the acquisition of assets from NMHC and the acquisitions of Valence Health, Aldera and New Century Health, which may be difficult to integrate, divert management resources, result in unanticipated costs or dilute our stockholders;
- our ability to consummate opportunities in our pipeline;
- certain risks and uncertainties associated with the acquisition of assets from NMHC and the acquisitions of Valence Health, Aldera and New Century 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;
- risks relating to our ability to maintain profitability for our and New Century Health’s performance-based contracts and products;
- the growth and success of our partners, which is difficult to predict and is subject to factors outside of our control, including enrollment numbers for our partner’s plans (including in Florida), 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 and succesfully capture new growth opportunities;
- 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 markets;
- 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 payer 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 ability to accurately underwrite performance-based contracts;
- risks related to our offshore operations;
- 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;
- the impact of changes in accounting principles and guidance on our reported results;
- 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 conditional conversion feature of the 2025 Notes, which, if triggered, could require us to settle the 2025 Notes in cash;
- the impact of the accounting method for convertible debt securities that may be settled in cash;
- 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 maintain effective internal control over financial reporting;
- our expectations regarding the additional management attention and costs that will be required as we have transitioned 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. We believe the data that third parties have compiled is reliable, but we have not independently verified the accuracy of this information and there is no assurance that any of the forecasted amounts will be achieved. 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. We provide integrated, technology-enabled services to our national network of leading health systems, physician organizations and national and regional payers across Medicare, Medicaid and commercial markets. 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.

We believe that the transition to value-based care is impacting the business model of both providers and payers and is impacting the reimbursement and delivery of care in all segments of the market, including Medicare, Medicaid and commercial markets. For providers, the transformation of the 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. To that end, we provide an end-to-end, built-for-purpose, technology-enabled platform for providers to transition their organization and business model to succeed in value-based payment models. To succeed under value-based care reimbursement, payers are under increasing pressure to manage high cost complex patient populations. We offer technology-enabled services to address these populations.

As of December 31, 2018, we had contractual relationships with over 35 operating partners. A significant portion of our revenue is concentrated with a single partner, Passport, which comprised 17.5% of our consolidated revenue for 2018. Recent changes in the way the state of Kentucky distributes federal Medicaid benefits have had a significant negative impact on Passport. See “Risk factors- Recent rate changes in Kentucky have negatively impacted Passport, our largest partner in terms of revenue for 2018, and could significantly harm our business, financial condition and results of operations” for additional information. As of December 31, 2018, our average contractual relationship with our operating partners was approximately 5.6 years. We believe our Services business model provides strong visibility and aligns our partners’ incentives with our own. 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 Services 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 participate alongside our partners in risk-sharing arrangements whereby we share in a portion of the upside and downside performance of the value strategy. 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 risk-sharing arrangements and co-ownership.

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 Services business model benefits from scale, as we leverage our purpose-built technology-enabled solutions and centralized resources in conjunction with the growth of our partners’ membership base. 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.

In October 2018, we acquired New Century Health, a national population health leader in managing specialty care for Medicare, commercial and Medicaid members under performance-based arrangements, focused primarily on oncology and cardiovascular care. In January 2018, we acquired a commercial health plan in New Mexico that focuses on small and large businesses, True Health.

We manage our operations and allocate resources across two reportable segments, our Services segment and our True Health segment.

Our Market Opportunity

For 2018, health care spending in the United States was projected to be approximately $3.5 trillion. The U.S. health care system is undergoing a shift to a value-based care delivery and reimbursement model. While there is not a universally agreed-upon definition of value-based care, we estimate that more than 50% of health care payments were paid through value-based care programs in 2018. This estimate is based on goals set by CMS, as well as statements made by the large health care insurers. Furthermore, we believe that there will be an increasing level of risk-transfer between payers and providers in value based care reimbursement. This was evident in CMS's "Pathways to Success" program launched in late 2018, which over time, will require ACOs to absorb the financial consequences of cost overruns within Medicare Shared Savings Programs. Our technology-enabled solutions allow providers and payers to capitalize on this transition, which we believe will position us to continue to be at the forefront of the transformation to value-based care.

Our Solutions

Services

Our Services segment includes three types of services designed to help our partners manage patient health in a more cost-effective manner: (1) value-based care services, (2) specialty care management services and (3) comprehensive health plan administration services. Our partners engage us to provide one type of service, or multiple types of services, depending on specific needs.

Value-based care services

Core elements of our value-based care services include: (1) Identifi®, our proprietary technology system that aggregates and analyzes data, manages care workflows and engages patients, (2) population health performance, which supports the delivery of patient-centric cost effective care, (3) delivery network alignment, comprising the development of high performance delivery networks and (4) integrated cost and revenue management solutions including PBM and patient risk scoring.

We integrate change management processes and ongoing physician-led transformation into all value-based services to build engagement, integration and alignment within our partners to successfully deliver value-based care and sustain performance. We have standardized the processes described below and are able to leverage our expertise across our entire partner base. Through the technological and clinical integration, we achieve, our solutions are delivered as engrained components of our partners' core operations rather than as add-on solutions.

Identifi®

Identifi® is our proprietary technology system that aggregates and analyzes data, manages care workflows and engages patients. Identifi® links our processes with those of our provider partners and other third parties to create a connected clinical delivery ecosystem, stratify patient populations, standardize clinical work flows and enable high-quality, cost-effective care. The configurable nature and broad capabilities of Identifi® help enhance the benefits our partners receive from our value-based care services and increase the effectiveness of our partners' existing technology architecture. Highlights of the capabilities of Identifi® include the following:

- *Data and integration services:* Data from disparate sources, such as EMRs, and lab and pharmacy data, is collected, assembled, integrated and maintained to provide health care professionals with a holistic view of the patient.
- *Clinical and business content:* Clinical and business content is applied to the integrated data to create actionable information to optimize clinical and financial performance.
- *EMR integration:* Data and clinical insights from Identifi® are fed back into partner EMRs to improve both provider and patient satisfaction, create workflow efficiencies, promote clinical documentation and coding and provide clinical support at the point-of-care.
- *Applications:* A suite of cloud-based applications manages the clinical, financial and operational aspects of the value-based model. Our applications are individually purchased and scale with the clinical, financial and administrative needs of our provider partners. As additional capabilities are required by our partners, they are often deployed as applications through Identifi®.

THIS DOCUMENT HAS BEEN TRUNCATED HERE AS IT'S SIZE EXCEEDS THE SYSTEM LIMIT

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