Evolent Health Annual Report 2020

Form 10-K (NYSE:EVH)

Published: March 2nd, 2020

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, 2019

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	Trading Symbol(s)	Name of each exchange on which registered
Class A Common Stock of Evolent Health, Inc., par value $0.01 per share	EVH	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 S 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 S

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 S 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 S No ☐

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 S 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 S

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 $600.0 million.

As of February 21, 2020, there were 84,722,479 shares of the registrant's Class A common stock outstanding.

Documents Incorporated by Reference

Selected portions of the Proxy Statement for the Annual Meeting of Shareholders, scheduled for June 9, 2020, 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, 2019.

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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;
- "ASO" means administrative services only, which refers to contracts with our partners wherein Evolent provides certain services on a fee-basis but does not assume responsibility for the cost of care;
- "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;
- "LSU" means leveraged stock unit;
- "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;
- "Passport Buyer" means Justify Holdings, Inc., a Kentucky corporation and a previous subsidiary of the Company
- "performance-based" means risk-based contracts with our partners wherein Evolent assumes financial responsibility for the cost of care, which may range from upside and downside gain share to all, or substantially all, of the responsibility for the cost of care within a defined scope subject to Evolent management controls and contractual protections;
- "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;
- “VIE” means variable interest entities; 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 our relationship or contract with Passport or another significant partner, or multiple partners in the aggregate;
- uncertainty relating to expected future revenues from Passport, and the value of our investment in Passport, including as a result of the ongoing Medicaid request for proposal process in the Commonwealth of Kentucky;
- 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 and 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 partnership with GlobalHealth, the acquisition of assets from New Mexico Health Connections ("NMHC"), and the acquisitions of Valence Health Inc., excluding Cicerone Health Solutions, Inc. ("Valence Health"), Aldera Holdings, Inc. ("Aldera"), NCIS Holdings, Inc. ("New Century Health"), and Passport, which may be difficult to integrate, divert management resources, or result in unanticipated costs or dilute our stockholders;
- our ability to consummate opportunities in our pipeline;
- risks relating to our ability to maintain profitability for our total cost of care and New Century Health's performance-based contracts and products, including capitation and risk-bearing contracts;
- the growth and success of our partners, which is difficult to predict and is subject to factors outside of our control, including governmental funding reductions and other policy changes, enrollment numbers for our partners' 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;
- our ability to attract new partners and successfully 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, including with respect to privacy of health information;
- 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;

- True Health's ability to enter the individual market;
- the risk of a significant reduction in the enrollment in our health plan;
- our ability to accurately underwrite performance-based risk-bearing 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 impact of additional goodwill and intangible asset impairments on our results of operations;
- our indebtedness, our ability to service our indebtedness, the impact of covenants in our credit agreement on our business, our ability to access the delayed draw loan under our credit facility and our ability to obtain additional financing;
- our ability to achieve profitability in the future;
- the impact of litigation, including the ongoing class action lawsuit;
- 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 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 Global, LLC (along with its affiliates, "TPG");
- our obligations to make payments under the tax receivables agreement that may be accelerated or may exceed the tax benefits we realize;
- 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;
- 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; and
- our ability to remediate our material weakness and to maintain effective internal control over certain instances of one of our claims processing systems.

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 1A. Risk Factors."

PART I

Item 1. Business

Market Opportunity

We are a market leader in the new era of value-based care, in which leading health systems and physician organizations, which we refer to as providers, as well as health plans, which we refer to as payers, are moving their business models from traditional FFS reimbursement to increasingly integrated clinical and financial responsibility for populations. We refer to our provider and payer customers as partners. We consider this integration of health care delivery and financial responsibility with the aim of lowering cost, enhancing quality, and improving satisfaction, to be the core of value-based care.

The U.S. healthcare market is projected to approach $3.8 trillion in spending during 2019, with less than half of payments tied to value-based care models. We believe the shift to value-based care is accelerating, driven by price pressure in traditional FFS health care, a policy and market environment that is incentivizing value-based care models and innovation in data and technology. We believe that the transition to value-based care is impacting the business models of both providers and payers in all segments of the market, including Medicare, Medicaid, and Commercial lines of business.

We believe providers are well-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 brands. Providers operating successfully in value-based arrangements can diversify their revenue streams, capture superior economics, and improve the quality of care they provide.

We also believe payers who successfully evolve their business model from that of FFS reimbursement towards value-based care can gain meaningful competitive advantages. Payers who successfully integrate care delivery and financing with providers stand to gain market advantage as medical expenses for their populations are lowered while also quality of care is improved.

The transformation of provider and payer business models from FFS to value-based care requires infrastructure that performs two functions: (i) the ability to create clinical value, which is typically defined as lowering the cost of care while maintaining or improving quality, that is superior to FFS, and (ii) an administrative platform on which to operate the value-based business. In addition to this infrastructure, we believe that participants in value-based arrangements also need sustainable contractual mechanisms to enable each party to capture clinical value that is created and sufficient lives in value-based arrangements to provide a return on infrastructure investments.

Our Business

Our History

Evolent was founded in 2011 by members of our management team, UPMC, an integrated delivery system in Pittsburgh, Pennsylvania, and The Advisory Board Company, to enable providers to pursue a value-based business model and evolve their competitive position and market opportunity. Since that time, we have grown both organically and through acquisitions. On February 1, 2016, the Company entered into a strategic alliance with Passport. In October 2016, we acquired Valence Health. Valence Health, based in Chicago, Illinois, was founded in 1996 and provides TPA services, value-based administration, population health and advisory services with a particular focus on the Medicaid and pediatric markets. On November 1, 2016, the Company completed the acquisition of Aldera, a key vendor and the primary software provider for the Valence Health TPA platform. In January 2018, we acquired a commercial health plan in New Mexico that focuses on small and large businesses, True Health. 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. On December 30, 2019, we closed a transaction whereby a subsidiary of the Company acquired substantially all of the assets and assumed substantially all of the liabilities of Passport and PHS I for $70.0 million in cash and issued a 30% equity interest in the Passport Buyer to the provider sponsors of Passport. We have also diversified and modified our service offerings and have expanded our addressable market to include payers and physicians as customers.

Today, we manage our operations and allocate resources across two reportable segments, our services segment and our True Health segment.

Services Overview

Our services segment includes clinical and administrative solutions designed to help our partners manage and administer patient health in a more cost-effective manner. We have two clinical solutions: (i) total cost of care management, and (ii) specialty care management services, and one administrative solution: comprehensive health plan administrative services. From time to time, we package our solutions under various go-to-market brand names to create product differentiation. Our partners may engage us to provide one type of solution, or multiple types of solutions, depending on specific needs.

The majority of our services revenue is derived from recurring multi-year contracts, which we refer to as platform and operations. Platform and operations services accounted for 77.9% and 79.8% of our consolidated revenue for the years ended December 31, 2019 and 2018, respectively. We believe the recurring, multi-year nature of our platform and operations contracts enables us to have strong visibility into future revenue. The amount of revenue in a given platform and operations contract is typically driven by: (i) the number of members that Evolent is contracted to manage, (ii) the population types being served (e.g., Medicare, Medicaid, Commercial), and (iii) the depth and breadth of the services and technology applications that our partners utilize from us. In situations involving clinical solutions, we typically elect to: (iv) participate alongside or co-own risk-sharing arrangements with our partners whereby we share in a portion of the upside and downside clinical performance, or by owning a portion of the underwriting results. We believe performance-based contracts align our partners' incentives with our own and gives us the opportunity to capture greater value from our contracts.

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.

The other portion of our services revenue, which we call transformation is typically composed of implementation services associated with our recurring revenue relationships. Due to the nature of recurring multi-year contracts, as we have added additional partners, the portion of our revenue that is one-time in nature has decreased to approximately 1%.

A significant portion of our services revenue is concentrated with a single partner, Passport (in which we now own a 70% equity interest), which comprised 18.7% of our consolidated revenue for 2019 which is recorded in platform and operations services on our consolidated statements of operations and comprehensive income (loss). Passport's current contract to provide managed care for Medicaid expires on December 31, 2020. Passport recently submitted a proposal to continue providing managed care for Medicaid in the Commonwealth of Kentucky through December 31, 2023 in response to the ongoing "request for proposal" process (the "RFP") of the CHFS. While Passport was not initially awarded a Kentucky managed Medicaid contract for the next contract period, the bidding process was reopened, and a revised proposal was submitted during the first quarter of 2020. Although we cannot guarantee the timing or outcome of the RFP, we expect CHFS to announce results of the RFP in the second quarter of 2020. Contracts awarded under the new RFP process are expected to begin January 1, 2021 and continue through December 31, 2024. We expect the outcome of the final RFP to have a material impact on our revenue from our management services agreement with Passport Buyer and the value of our investment in Passport beyond the current contract period. If Passport is not awarded a contract under the RFP, we expect that we will not receive any material revenue under our management services agreement from Passport Buyer subsequent to December 31, 2020 and the value of our goodwill and investment in Passport will be negatively impacted.

Clinical Solutions

We have two clinical solutions: total cost of care management and specialty care management services. We manage both of these solutions in our services segment.

Total Cost of Care Management Solution

Our total cost of care management solution was developed based on the intellectual property contributions of UPMC at our founding. Since then, we have continued to invest in the solution to broaden, deepen and scale its capabilities.

Our total cost of care management solution enables providers to manage populations they may be accountable for under value-based contracts with payers or ACO contracts with CMS. This solution seeks to reduce the total cost of care for a given population by identifying and managing high cost patients with targeted interventions managed and coordinated through primary care physicians. The economic model of our total cost of care management solution is primarily performance-based, which we believe enhances our ability to influence provider behavior by aligning our incentives with our partners. We estimate the total addressable market size of our total cost of care management solution to be approximately $60 billion. We use, and may continue to use, different go-to-market brand names for various solution packages, depending on the markets we seek to address. These go-to-market brand names include: (i) Value Based Services, wherein we support primarily health systems in their value-based operations, and (ii) Evolent Care Partners, wherein we offer physicians the opportunity to join Evolent's proprietary payer contracting vehicles, scaled risk pools, and operating model.

We refer to the offerings within this solution as 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 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.