Evolent Health, Inc.
Form 424B7
May 17, 2017
Table of Contents

Filed Pursuant to Rule 424(b)(7)
Registration No. 333-212709

Prospectus supplement

(To Prospectus dated March 27, 2017)

7,000,000 shares

Evolent Health, Inc.

Class A common stock

The shares of Class A common stock in the offering are being sold by the selling stockholders identified in this prospectus supplement. See Selling stockholders. We will not receive any proceeds from the sale of shares offered by the selling stockholders.

The shares of Class A common stock included in this offering include 3,791,515 shares of our Class A common stock to be issued upon exchange of an equivalent number of Class B common units (together with an equal number of shares of our Class B common stock) of our operating subsidiary, Evolent Health LLC, by the selling stockholders named in this prospectus supplement pursuant to their contractual rights under an exchange agreement. See Certain Contractual Arrangements with Stockholders Third amended and restated operating agreement of Evolent Health LLC in the accompanying prospectus for a detailed description of the right to exchange.

Our Class A common stock is traded on the New York Stock Exchange under the symbol EVH. The last reported sale price of our Class A common stock on May 15, 2017 was $24.95 per share.

We are an emerging growth company under the Jumpstart Our Business Startups Act of 2012 and are therefore subject to reduced reporting requirements.

Investing in our Class A common stock involves risks. You should carefully read and consider the Risk Factors section on page S-21 of this prospectus supplement before investing in our Class A common stock.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus supplement or the accompanying prospectus are truthful or complete. Any representation to the contrary is a criminal offense.

	Per share	Total
Public offering price	$ 24.65	$ 172,550,000
Underwriting discounts and commissions	$ 0.35	$ 2,450,000
Proceeds to selling stockholders	$ 24.30	$ 170,100,000

We have agreed to reimburse the underwriters for certain expenses related to the review and qualification of this offering by the Financial Industry Regulatory Authority, Inc. See Underwriting.

If all of the shares are not sold at the public offering price, the underwriters may change the offering price and may offer shares from time to time for sale in negotiated transactions or otherwise, at market prices prevailing at the time of sale, at prices related to such prevailing market prices or otherwise.

The underwriters expect to deliver the shares to purchasers on or about May 19, 2017.

Morgan Stanley **J.P. Morgan** **Goldman Sachs & Co. LLC**

Prospectus supplement dated May 15, 2017.

Table of Contents

Table of contents

Prospectus supplement

Prospectus dated March 27, 2017

None of we, the selling stockholders or any underwriter has authorized anyone to provide any information other than that contained or incorporated by reference in this prospectus supplement, the accompanying prospectus or in any free writing prospectus prepared by or on behalf of us or the selling stockholders or to which we have referred you. None of we, the selling stockholders or any underwriter take responsibility for, or can provide assurance as to the reliability of, any other information that others may give you. This prospectus supplement and the accompanying prospectus is an offer to sell only the Class A common stock offered hereby, but only under circumstances and in jurisdictions where it is lawful to do so. The information contained in this prospectus supplement, the accompanying prospectus, any free writing prospectus or any document incorporated by reference herein or therein is current only as of its date. Our business, financial condition, results of operations and prospectus may have changed since that date.

No action is being taken in any jurisdiction outside the United States to permit a public offering of our Class A common stock or possession or distribution of this prospectus supplement in that jurisdiction. Persons who come into possession of this prospectus supplement in jurisdictions outside the United States are required to inform themselves about and to observe any restrictions as to this offering and the distribution of this prospectus supplement applicable to that jurisdiction.

Table of Contents

About this prospectus supplement

This document consists of two parts. The first part is this prospectus supplement, which describes the specific terms of the offering. The second part is the accompanying prospectus, which describes more general information, some of which may not apply to the offering. You should read both this prospectus supplement and the accompanying prospectus, together with additional information described under the headings Where You Can Find More Information and Incorporation by Reference in this prospectus supplement. To the extent there is a conflict between the information contained in this prospectus supplement and the information contained in the accompanying prospectus or the information contained in any document incorporated by reference herein or therein, you should rely on the information in this prospectus supplement. In addition, any statement in a filing we make with the Securities and Exchange Commission (the SEC), that adds to, updates or changes information contained in an earlier filing we made with the SEC shall be deemed to modify and supersede such information in the earlier filing.

Except as otherwise indicated or required by the context, (i) references in this prospectus supplement to Evolent, we, our, us and our company refer to Evolent Health, Inc., a Delaware corporation, together with its consolidated subsidiary, Evolent Health LLC, a Delaware limited liability company; (ii) UPMC refers to University of Pittsburgh Medical Center; (iii) TPG refers to TPG Global, LLC and certain of its affiliates; (iv) The Advisory Board refers to The Advisory Board Company; (v) Ptolemy refers to Ptolemy Capital, LLC; and (vi) Investor Stockholders refer to UPMC, TPG, The Advisory Board and Ptolemy.

This prospectus supplement and the accompanying prospectus dated March 27, 2017 are part of the Registration Statement (Registration No. 333-212709) that we filed with the SEC on July 28, 2016, using a shelf registration process. This prospectus supplement relates to the offering of shares of our Class A common stock by the selling stockholders identified herein.

Table of Contents

Special note regarding forward-looking statements

Certain statements made in this prospectus supplement and the accompanying prospectus and the documents incorporated herein and therein by reference 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, shou 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;
- the uncertain impact the results of the 2016 presidential and congressional 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;
- our ability to offer new and innovative products and services;
- risks related to completed and future acquisitions, investments and alliances, including the acquisitions of Valence Health, Inc., excluding Cicerone Health Solutions, Inc. (Valence Health), and Aldera Holdings, Inc. (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 Valence Health, including revenues of Valence Health before and after the merger 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 and the ability to control and, if necessary, reduce health care costs;

our ability to attract new 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;

Table of Contents

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 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 (Class B common units) 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;

Table of Contents

the potential decline of our Class A common stock price if a substantial number of shares 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 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 status as an emerging growth company ; 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. Our Annual Report on Form 10-K for the fiscal year ended December 31, 2016, our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 and our other documents filed with the SEC include additional factors that could affect our businesses and financial performance. 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 prospectus supplement.

Table of Contents

Where you can find more information

We are subject to the information and reporting requirements of the Securities Exchange Act of 1934, as amended (the Exchange Act), and, accordingly, file annual, quarterly and periodic reports, proxy statements and other information with the SEC. You may read and copy any reports, statements or other information we file with the SEC at the Public Reference Room of the SEC, 100 F Street, NE, Washington, D.C. 20549. Please call the SEC at 1-800-SEC-0330 for further information on the operation of the Public Reference Room. You may also obtain copies of this information by mail from the Public Reference Room of the SEC, 100 F Street, NE, Washington, D.C. 20549, at prescribed rates, or from commercial document retrieval services.

We have filed with the SEC a registration statement on Form S-3, including exhibits filed with the registration statement of which this prospectus supplement is a part, under the Securities Act of 1933, as amended (the Securities Act), with respect to the shares of our Class A common stock offered hereby. This prospectus supplement and the accompanying prospectus do not contain all of the information set forth in the registration statement and exhibits to the registration statement. For further information with respect to our company and shares of our Class A common stock offered hereby, reference is made to the registration statement, including the exhibits to the registration statement. Statements contained in this prospectus supplement and the accompanying prospectus as to the contents of any contract or other document referred to in this prospectus supplement and the accompanying prospectus are not necessarily complete and, where that contract is an exhibit to the registration statement, each statement is qualified in all respects by the exhibit to which the reference relates. Copies of the registration statement, including the exhibits to the registration statement, may be examined without charge at the Public Reference Room of the SEC, in the manner described above.

Our SEC filings, including our registration statement, are also available to you, free of charge, on the SEC s website at www.sec.gov. Our SEC filings will also be available on our website at ir.evolenthealth.com. The information contained on or linked to or from our website is not incorporated by reference into this prospectus supplement, the accompanying prospectus or the registration statement of which they form a part.

Incorporation by reference

This prospectus supplement is part of a registration statement on Form S-3 filed with the SEC. This prospectus supplement does not contain all of the information included in the registration statement, certain parts of which are omitted in accordance with the rules and regulations of the SEC.

The SEC allows us to incorporate by reference certain information into this prospectus supplement from certain documents that we filed with the SEC prior to the date of this prospectus supplement. By incorporating by reference, we are disclosing important information to you by referring you to documents we have filed separately with the SEC. The information incorporated by reference is deemed to be part of this prospectus supplement and the accompanying prospectus, except for information incorporated by reference that is modified or superseded by information contained in this prospectus supplement or the accompanying prospectus or in any other subsequently filed document that also is incorporated by reference herein. Any statement so modified or superseded will not be deemed, except as so modified or superseded, to be part of this prospectus supplement and the accompanying prospectus. These documents contain important information about us, our business and our financial performance.

(1) Our Annual Report on Form 10-K for the year ended December 31, 2016 filed with the SEC on March 3, 2017 (our 2016 10-K);

(2) Our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 filed with the SEC on May 10, 2017;

(3) The portions of our Definitive Proxy Statement on Schedule 14A filed with the SEC on April 27, 2017 that are incorporated by reference into Part III of our 2016 10-K;

Table of Contents

(4) The description of our Class A common stock included in our registration statement on Form 8-A filed with the SEC on June 5, 2015; and

(5) Amendment No. 1 to our Current Report on Form 8-K/A filed with the SEC on December 19, 2016 (solely with respect to Exhibits 23.1, 99.1 and 99.2 of Item 9.01) and our Current Reports on Form 8-K filed with the SEC on February 8, 2017, March 27, 2017, March 31, 2017 and May 1, 2017.

We also specifically incorporate by reference any documents filed by us with the SEC pursuant to Sections 13(a), 13(c), 14 or 15(d) of the Exchange Act after the date we file this prospectus supplement and prior to the termination of the offering of securities covered by this prospectus supplement, except for any document or portion thereof deemed to be furnished and not filed in accordance with SEC rules. The information relating to us contained in this prospectus supplement does not purport to be comprehensive and should be read together with the information contained in the documents incorporated or deemed to be incorporated by reference herein.

If you request, either orally or in writing, we will provide you with a copy of any or all documents that are incorporated by reference herein. Such documents will be provided to you free of charge, but will not contain any exhibits, unless those exhibits are incorporated by reference into the document. Requests can be made by writing to Investor Relations at 800 N. Glebe Road, Suite 500, Arlington, Virginia 22203 or by phone at (571) 389-6000. The documents may also be accessed on our website at ir.evolenthealth.com. Information contained on our website is not incorporated by reference into this prospectus supplement, the accompanying prospectus or the registration statement of which they form a part.

Table of Contents

Our company

We are a market leader and a pioneer 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 fee-for-service (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 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 approximately ten percent 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 fifty percent by 2020. There were over 100 provider-owned health plans as of 2014 and this number continues to grow. The number of accountable care organizations (ACOs), or organizations of groups of doctors, hospitals and other health care providers which have come together voluntarily to provide coordinated care to their Medicare patients constructed to manage capitated or value-based arrangements with existing insurance companies or government payers, grew to 742 by the end of 2014.

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. The core elements of our platform include:

Integrated technology, ***proprietary process and clinical 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.

Supporting multiple value-based care models, our platform was built to support a diverse set of provider value-based care strategies ranging from shared medical savings arrangements to launching health plans in both public and private markets.

Identifi®, our technology platform, delivers the data aggregation and stratification, proven value-based care content, electronic medical records (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,

Table of Contents

(2) a high-performing population health organization that drives clinical outcomes, (3) an efficient administrative infrastructure to administer value-based payments and (4) integration of cost management solutions, such as pharmacy benefit management (PBM), or 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, and patient risk scoring.

Long-term, ***embedded and aligned partnerships with health systems*** to enable us and our provider partners to grow together as we manage increasing populations under value-based care arrangements.

Payer-agnostic and 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 platform becomes the standard for value-based care contracting and operations.

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. Our mission, technology and services were developed with UPMC, which operates the nation s largest provider-owned health plan after Kaiser Permanente, and The Advisory Board, whose best practice research and technology solutions were available to a membership base of over 4,400 hospitals and providers as of December 2016.

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. At the time of the acquisition, Valence Health was supporting approximately 0.5 million lives across ten long-term operating partners with one additional partnership supporting approximately 0.4 million lives due to come onto the platform on January 1, 2017. 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 long-term operating agreements.

We have developed what we believe is a unique partner development model. Most partner relationships begin with our transformation services, during which a partner engages us to develop a customized value-based care execution plan. This allows us to define the opportunity for our partners and embed our technology and processes while building confidence and trust that we are the best long-term infrastructure partner for the provider s value-based care strategy. We then transition our partner to our platform and operations phase, which is governed by a long-term contract. We incur significant expenses in securing new partner relationships, and, in 2016, our business development expenses represented 6.4% of our total revenues.

We believe our business model provides strong visibility and aligns our partners incentives with our own. 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 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 and by adding new partners.

We believe we are in the early stages of capitalizing on these long-term aligned partnerships. We believe our health system partners current value-based care arrangements represent a small portion of the health system s

Table of Contents

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 platform and centralized resources in conjunction with the growth of our partners membership base. These resources include our network development capabilities, 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.

Recent development

Acquisition of Valence Health, Inc. On October 3, 2016, we completed our acquisition of Valence Health. Valence Health, based in Chicago, Illinois, was founded in 1996 and provides value-based administration, population health and advisory services. In its 20 year history, Valence Health has developed particular expertise in the Medicaid and pediatric markets. The addition of Valence Health is expected to strengthen our operational capabilities and provide increased scale and client diversification. The merger consideration, net of certain closing and post-closing adjustments, was $217.0 million based on the closing price of our Class A common stock on the New York Stock Exchange on October 3, 2016, and consisted of 7.0 million shares of our Class A common stock and $54.8 million in cash. The shares issued to Valence Health stockholders represented approximately 10.5% of our issued and outstanding Class A common stock and Class B common stock immediately following the transaction.

Our market opportunity

In 2016, health care spending in the United States was projected to be more than $3.0 trillion, of which we estimate $1.0 trillion to be waste. We believe that a fundamental shift to value-based care can address this $1.0 trillion opportunity. 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 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 $46.0 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% to 50%, and the provider-sponsored health plan market representing 15% of total health plan membership.

Our solution

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

Our long-term partnerships typically begin with a system transformation process called the Blueprint, where we work with a provider s board of directors and senior management to assess their ability to succeed in value-based payment models. This process acts as a channel for long-term partnerships, as a significant portion of providers that make an investment in a Blueprint continue to partner with us for our proprietary processes and integrated services, which we refer to as our Value-Based Operations.

Table of Contents

Once our platform is integrated into the clinical and financial systems of our provider partners through the Blueprint and implementation phase, our Value-Based Operations, including our technology-enabled services platform, support the execution and administration of a provider s value-based care models on an ongoing basis. Value-Based Operations include Identifi®, our technology backbone, Population Health Services to enable provider-led management of the population and Financial and Administrative Management to measure performance and administer and capture the value of improved care.

Supporting multiple value-based care models

Our 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 payers (including commercial insurers and the government) that include a full spectrum of risk for bundled payments, pay for performance to full capitation

Health plan: Launching a provider-owned health plan allows providers to control all of the health care insurance premiums, or premium dollars, across multiple populations, including commercial, Medicare and Medicaid

Our partners benefit from a single platform that enables them to utilize our core suite of ongoing solutions, regardless of the size or type of value-based care models they are pursuing. Our platform grows through health systems increasing membership in their existing value-based care payment model, as well as their pursuit of additional payer contracts and health plans.

Identifi®

Identifi® is our proprietary technology platform 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 in order 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 Operations 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 in order 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 in order 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 through our platform, they are often deployed as applications through the Identifi® platform.

Table of Contents

Value-Based Operations

Our 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, (3) an efficient administrative infrastructure to administer value-based payments and (4) integration of cost 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 in order 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 ingrained components of our partner s core operations rather than add-on solutions.

Delivery network alignment

We help our partners build the capabilities that are required to develop and maintain a coordinated and financially-aligned provider network that can deliver high-quality care necessary for value-based contracts. These capabilities include:

- High-performance network: Supporting the capabilities needed to build, maintain and optimize provider- and clinically-integrated networks.
- Value compensation models: Developing and supporting physician incentive payment programs that are linked to quality outcomes, payer shared savings arrangements and health plan performance.
- Integrated specialty partnerships: Supporting the technology-enabled strategies, analytics and staff needed to optimize network referral patterns.

Population Health Performance

Population Health Performance is an integrated suite of technology-enabled solutions that supports the delivery of quality care in an environment where a provider s need to manage health has significantly expanded. These solutions include:

- Clinical programs: Care processes and ongoing clinical innovation that enables providers to target the right intervention at the right time for a given patient.
- Specialized care team: Multi-disciplinary team that is deployed telephonically from a centralized location or throughout a local market to operate clinical programs, engage patients and support physicians.
- Patient engagement: Integrated technologies and processes that enable outreach to engage patients in their own care process.

Quality and risk coding: Engagement of physicians to identify opportunities to close gaps in care and improve clinical documentation efforts.

Financial and administrative management

We help providers assemble the complete infrastructure required to operate, manage and capitalize on a variety of value-based payment arrangements. These capabilities include:

Payer risk: The capabilities needed to successfully manage risk from payers, including analysis, data and operational integration with payer processes, and ongoing performance management. Included in this capability is our Payer Value Alliance, which leverages our national scale to support providers with a common, sustainable, financial and clinical framework across contracted payers.

Table of Contents

Analytics and reporting: The ongoing and ad hoc analytic teams and reports required to measure, inform and improve performance, including population health analytics, market analytics, network evaluation, staffing models, physician effectiveness, clinical delivery optimization and patient engagement.

Health plan: The scaled administrative capabilities required to launch and operate a provider-sponsored health plan, including sales and marketing, product development, actuarial, regulatory and compliance, member services, claims administration, provider relations, finance and utilization management.

Leadership and management: Our local and national talent assist our partners in effectively managing the performance of their value-based operations.

Integrated Cost and Revenue Management Solutions

We seek to integrate traditional cost and revenue management solutions such as PBM and risk adjustment to achieve greater adoption and performance than traditional payer-led models.

Pharmacy benefit management

Our team of professionals support the drug component of providers plan offerings and bring national buying power and dedicated resources that are tightly integrated with the care delivery model. Differentiated from what we consider to be traditional PBMs, our solution is integrated into patient care and engages population health levers including generic utilization, provider management, and utilization management to reduce unit pharmacy costs.

Risk adjustment

Our provider-led risk adjustment solution leverages our Identifi® platform and integrates with partners EMRs to minimize disruption to the physician practice and maximize physician engagement. Our prospective and retrospective risk adjustment offerings utilize comprehensive data sources to capture medical history and sophisticated analytics and workflow tools with the aim of increasing the accuracy and efficiency of retrieval and documentation. We believe that through better provider engagement and intelligent use of data, our integrated model drives more accurate documentation of patient acuity, which optimizes reimbursement and improves the quality of care.

Centralized infrastructure

Our solution was built to provide operating leverage that benefits from our continued growth. We leverage our purpose-built technology platform and centralized resources in conjunction with the growth in our partners membership base. Our centralized resources and technologies include our network development capabilities, PBM administration, technology infrastructure, clinical program development and data analytics.

Competitive strengths

We believe we are well-positioned to benefit from the transformations occurring in health care payment and delivery described above. We believe this new environment that rewards the better use of information to drive patient outcomes aligns with our platform, recent investments and other competitive strengths.

Early innovator

We believe we are an innovator in the delivery of a comprehensive value-based care solution for providers. We were founded in 2011, ahead of the implementation of the Patient Protection and Affordable Care Act and before the rapid expansion of programs, such as Medicare ACOs or Medicare Bundled Payment Initiatives. Since our inception, we have invested a significant amount in our offerings.

Table of Contents

Comprehensive end-to-end solution

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. We believe that offering a comprehensive and integrated solution which brings together population health management along with financial and administrative management on a single platform allows providers to accelerate their path to adoption of value-based care.

Integrated technology platform

Our proprietary technology platform, Identifi®, allows us to deliver a connected delivery ecosystem, implement replicable clinical processes, scale our Value-Based Operations and capitalize on multiple types of value-based payment relationships. The Identifi® platform supports the following capabilities:

Data aggregation from internal and external sources, such as EMRs and payer claims;

Algorithmic interpretation of aggregated data to stratify populations and identify high-risk patients;

Standardized workflows and dashboards to enable consistency across disparate clinical resources;

Applications to support value-based business models;

Patient outreach and engagement tools;

Integration into physician workflows to proactively engage high-priority patients; and

Reporting and tracking of clinical and financial outcomes.

We believe we are creating scaled benefits for our provider partners in areas such as data analytics, administrative services and care management. We expect Identifi® to enable us to deliver increasing levels of efficiency to our provider partners.

Provider-centric brand identity

We believe our provider-centric brand identity and origins differentiate us from our competitors. We believe our solutions, which have built on capabilities developed at UPMC, resonate with potential partners seeking proven solutions from providers rather than payers or non-health care businesses. Our analytical and clinical solutions are rooted in UPMC s experience in growing a provider-led, integrated delivery network over the past 15 years, and growing to become one of the largest provider-owned health plans in the country. In addition, our deep strategic partnership with The Advisory Board strengthens our brand as a provider-friendly organization. The Advisory Board is well-recognized as an industry thought leader that made its research and technology solutions available to over

4,400 hospitals and providers as of December 2016. Our position as a payer-agnostic services organization allows for the sharing of data across multiple payers and care delivery integration regardless of payer, which we believe is not possible with payer led solutions.

Partnership-driven business model

Our business model is predicated on long-term strategic partnerships with leading providers that are attempting to evolve two of their most critical business functions: how they deliver care and how they are compensated for it. The partnership model enables cultural alignment, integration into the provider care delivery and payment work flow, long-term contractual relationships and a cycle of clinical and cost improvement with shared financial benefit. We devote significant resources, primarily in the form of business development, to establish relationships with our partners. For 2016, our business development expenses represented 6.4% of our total revenues. Thereafter, beginning with the Blueprint phase of our engagement with a partner, our costs to serve our

Table of Contents

partners primarily consist of personnel-related costs for the deployment of our solution. We expect our business development expenses as a percentage of revenue to decline over time. As of March 31, 2017, our average contractual relationship with our long-term partners was approximately five years, with an average of 2.2 years of performance remaining per contract. As of March 31, 2017, we had entered into long-term contractual relationships with over 25 partners and a significant portion of our revenue is concentrated with several partners. Our two largest partners for the three months ended March 31, 2017, Passport Health Plan and MDWise, Inc., comprised 17.1% and 11.2%, respectively, of our revenue over such period, or 28.3% in the aggregate. See Part I Item 2. Management s Discussion and Analysis of Financial Condition and Results of Operations Business Overview of our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 for additional discussion about our largest partners.

Channel development

Our heritage, having been founded by UPMC, one of the largest providers in the country, and The Advisory Board with over 4,400 hospital and provider members as of December 2016, along with the relationships fostered by our senior management team, have allowed us to develop a significant channel into leading health systems. Our solution empowers a fundamental shift in a provider s business model and requires alignment of their senior management and board of directors for success. A significant portion of providers that make an investment in a Blueprint continue to partner with us for our proprietary process and integrated services, which we refer to as our Value-Based Operations.

Our business model creates additional channel development through our Blueprint services. Our Blueprint not only enables providers with a roadmap to value-based care and the financial implications of the transition, it also creates a connection between us and the provider s senior leadership. As a result, we derive revenues from providers who have completed the Blueprint phase and proceed to partner with us to enable their transition to value-based contracting.

Proven leadership team

We have made a significant investment in building an industry-leading management team. Our senior leadership team has extensive experience in the health care industry and a track record of delivering measurable clinical, financial and operational improvement for health care providers and payers. Our chief executive officer, Frank Williams, was formerly the chief executive officer of The Advisory Board, where he oversaw the growth of the company and its IPO.

Growth opportunities

Multiple avenues for growth with our existing, embedded partner base

We have established a multi-year partnership model with multiple drivers of embedded growth through the following avenues:

- growth in lives in existing covered populations;
- partners expanding into new lines of value-based care to capture growth in new profit pools; and
- partners utilizing our additional capabilities, such as new Identifi® applications, PBM and third party administration, which is the processing of insurance claims or the administration of certain aspects of

employee benefits plans for a separate entity.

In addition to growth within our existing partner base, opportunities exist with providers utilizing our Blueprint, who sign short-term contracts under which we analyze the opportunities available to them in the value-based care market. From time to time, we also evaluate and consider pursuing opportunities to expand into businesses related to the services we currently provide.

Table of Contents