Achieving Superior Performance Through Value-Based Care Transformation

February 7, 2019
Prepared for: 2019 HFMA Managed Care Symposium
Presented by: Frank Williams, Evolent Health CEO
Evolent Health Overview

**mission**
To change the health of the nation by changing the way health care is delivered

**Evolent Health footprint**

**focus and differentiation**
We collaborate with providers and payers to drive and monetize substantial improvements in clinical value

~3.5M
Lives supported

35+
Partners

41K+
Hospital days avoided in 2018

3.7K+
Employees
Logic Around the Move to Value
Dizzying News Cycle

**May 2017**
May 4: After multiple false starts, House passes AHCA

**Dec. 22: Signs bill into law; repeals ACA’s individual mandate penalty**

**May 2018**
End of MSSP Track 1 with rising costs in the news

**December 2018**
New rule limits immigrants’ access to Medicaid

July 25-28: Senate votes down BCRA, ORRA, HCFA

1) American Health Care Act
2) Better Care Reconciliation Act
3) Obamacare Repeal Reconciliation Act
4) Health Care Freedom Act

In the Face of It All, We Forge Ahead

Value has moved at a slower pace, search for scale

The innovator has been the government, not the private sector or national payers

A provider-driven clinical model actually works; however, it’s critical to capture value from meaningful differentiation

Moving up the risk continuum and gaining scale/experience are critical for success

Hospital-less IDNs, activist employers and govt performance standards are new disruptors
Macro Forces are Still in Tact
Transition to Value by the Numbers

Unsustainable Costs

20% share of US GDP 2025

40% share of federal budget 2025

28% Medicaid share of state budget

3X per capita spending v. OECD

Deteriorating Health (US v. OECD)

6.0 v. 4.1 infant mortality rate

76.4 v. 77.8 life expectancy

35.3% v. 23.2% obesity rate

Patients Paying and Delaying Care

30% employees in HDHPs (Kaiser)

35% patients delaying procedures (Gallup)

Provider Consolidation

65% — 46% hospitals in health systems (2015 v. 2001)

57% — 33% physician employment (2016 v. 2000)

100% growth in acute care acquisitions (2015 v. 2010)

Sources: Congressional Budget Office; Goldman Sachs, "Healthcare’s Holy Grail – The Shift to Value-Based Reimbursement", February 2, 2017
Traditional Strategy Dependent Upon Price, Network Assumptions Which Are Being Challenged

Traditional Assumptions Underlying Provider Growth Strategy

**Entrenched Payer**
- Maintain broad provider networks
- Pass excess cost growth on to employers through brokers

**Established Provider**
- Expect steady public-payer, commercial price growth
- In-network for most plans

**Price-Insulated Patient**
- Open access to broad provider network
- Seek care with little concern for out-of-pocket payment

Source: The Advisory Board Company
Medicare is a Microcosm for Trends Across the Health Care Payment Landscape

1. Medicare Payment Innovation
   - New risk-based payment models
   - Growth of Medicare Advantage

2. Market-Based Medicaid Reform
   - Growth of Medicaid Managed Care
   - Commercialization through “Private Option”

3. Increased Commercial Market Competition
   - Increased use of narrow networks
   - New channels for competition in group market

Source: The Advisory Board Company
Bright Prospects for Medicare

Both Payment, Coverage Reforms Will Bolster Existing MA Market Growth

MA Enrollment to Nearly Double by 2025

CMS Encouraging MA Expansion

Changes Proposed in 2018 IPPS Update

- Higher Payment Rates
  On average, plans will see a payment update of 0.45% supplemented by an expected growth in high acuity coding increasing average revenue by 2.95%

- Increased Quality Incentives
  Plans delivering higher quality care, more benefits can earn higher rate updates going forward

MACRA Already Moving the Dial on Participation in Downside Models Source

<table>
<thead>
<tr>
<th>Year</th>
<th>Participants in downside ACO models</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>40</td>
</tr>
<tr>
<td>2017</td>
<td>87</td>
</tr>
</tbody>
</table>

Percent increase in downside ACO model participation, 2016-2017: 117%

Medicaid Budget Pressures Creating Impetus for Reform and Pushing Risk to Providers and Payers

Three Non-Traditional Models for Medicaid Reform

- **Expansion of Traditional Medicaid**
- **Full Medicaid Managed Care**
  *E.g., Florida’s Statewide Medicaid Care Program*
- **Provider-Led Care Management**
  *E.g., Oregon’s “Coordinated Care Organizations”*
- **Exchange-Based Privatization**
  *E.g., Arkansas’ “Private Option”*

Source: The Advisory Board Company
Employer Health Spending Continues to Grow

Even Without Regulatory Pressure, Employers Still Have a Cost Problem

~49% US population covered by employer-sponsored insurance

Average Annual Growth Rate Among Private Business’s Health Expenditures

*FY 2014-2017*

Employers Use Scale to Incentivize Transformation, Helping Employees Make High-Value Choices

Health Transformation Alliance Priorities

**Prescription Drug Purchasing**
- Three-year contract with CVS and OptumRx
- Members receive full transparency on rebates / discounts, ability to audit fees, participate in formulary decision-making

**Data and Analytics**
- Contract with IBM Watson Health
- Aggregate / analyze claims data to better understand impact of medical interventions and wellness

**Narrow Network Curation**
- Partnering with Cigna and United
- Payers to build high-value networks for Diabetes, joint replacements & back pain - Dallas, Phoenix, Chicago

Cost shifting to employees remains the dominant response.

(2) Kaiser Family Foundation

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Innovators Doubling Down on Ambulatory Care

Meeting Demands of Market Requires New Forms of Partnership

**ACCESS**

GoHealth Urgent Care

Partnered with:
- **Legacy Health** (18 clinics)
- **Dignity Health** (8 clinics)
- **Northwell Health** (35 clinics)
- **Hartford HealthCare** (8 clinics)

**DIAGNOSTICS**

Smart Choice MRI

Partnered with:
- **ThedaCare** ($3M investment)
- **Edward-Elmhurst Health** ($7M investment)

**PROCEDURES**

United Surgical Partners International

Partners include:
- **Tenet Healthcare** ($425M investment for 50.1% stake)
- **Baylor Scott & White Health** (25 ASCs and 7 short-stay hospitals)
- Over 50 other health systems

“Smart Choice MRI shares our vision to put patients and consumers at the center of the health care experience. We sometimes collaborate with competitors in the best interests of consumers.”

*Keith Livingston*

*SVP of Systems of Care Support, ThedaCare*

An Industry in Flux

Unprecedented Mega-Mergers Claiming the Spotlight

Drivers of Deal Activity

- **Tax reform** brings for-profit companies an influx of cash
- **Shifting administrative priorities** changes sources of projected growth
- **Margin pressure** intensifies capital needs in certain sectors

Potential Industry Disruption

- UnitedHealth Group: $230.2B**
- CVS Health: $66.9B
- Walgreens: $75.7B**
- Aetna: $57.9B
- Cigna: $42.8B
- Express Scripts: $41.4B
- DaVita Medical Group: $4.9B**
- Humana: $40B

Combined Market Valuation*

*Advisory Board is a subsidiary of UnitedHealth Group, the parent company of UnitedHealthcare. All Advisory Board research, expert perspectives and recommendations remain independent.

**UnitedHealth Group’s Purchase Price


14 **UnitedHealth Group’s Purchase Price
Hospital Economics Under Siege

Expense Growth Continues to Outpace Revenue Growth

Revenue and Expense Growth Rates for Non-Profit Hospitals

2009-2017 Medians

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue Growth</th>
<th>Expense Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>5.7%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>7.1%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>7.6%</td>
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</tr>
</tbody>
</table>

Median operating margin among not-for-profit hospitals in 2017; an all-time low

1.6%

Costs outgrow revenue again, gap widens

Operating margins at an all-time low

Second consecutive year of declining revenue growth

Economic Model at a Crossroads

Reimbursement Model and Customer Needs Shifting Simultaneously

Yesterday’s Model: Privately-Reimbursed Procedural Care

Largest patient base comprised of commercially-insured, middle-aged patients in need of imaging services and surgeries

Today’s Model: Publicly-Reimbursed Medical Care

Patients covered by Medicare or HDHPs, in need of medical mgmt, low-acuity preventive care

“If you have a commercial cost structure and you’re getting public reimbursement, there’s no silver bullet that will save you. You could pull every utilization and care management lever under the sun, and you’d still be underwater.”

VP of Strategy
Integrated Delivery System in the Northeast

The Next Era of Health Care Reform

Four Key Forces Shaping the Next Era of Reform

1. Direct reimbursement pressure
2. Federalism and state-based coverage reform
3. Dilution of employer-sponsored insurance
4. Deregulation and the new era of competition

Projected Hospital Margin in 2025: (0.2)%

The Bifurcation of the Health Care Consumer

Retirees and Millennials Have Vastly Different Demands From Middle-Aged

30s-40s
Happy and Unhappy
Accidents

Health Care Needs:
• Low-to-mid acuity urgent care
• Women’s health, maternity care
• Pediatrics

40s-60s
Repair and Replace

Health Care Needs:
• Imaging
• Surgeries

60s-90s
Maintain and Decline

Health Care Needs:
• Chronic disease management
• Cancer care
• Post-acute care, palliative care

Millennials: ~79.4M
Gen X: ~65.7M
Baby Boomers: ~75.5M

Provider Customer Base

The Challenges of Changing a Business Model
An Example
Providers Move Up the Value Chain

But Health Plan Ownership Entails Distinct Challenges

Growth in PSHP\textsuperscript{1} Enrollment

\textit{Millions}

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
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<tbody>
<tr>
<td>2010</td>
<td>12.4</td>
</tr>
<tr>
<td>2011</td>
<td>12.7</td>
</tr>
<tr>
<td>2012</td>
<td>12.9</td>
</tr>
<tr>
<td>2013</td>
<td>13.7</td>
</tr>
<tr>
<td>2014</td>
<td>15.3</td>
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</tbody>
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1\textsuperscript{1} Provider sponsored health plan.

Far From a Slam-Dunk Investment

- “Catholic Health Initiatives to Divest Health Plan Operations”
- “Health Plan Joint Venture Sustains Large Losses”
- “Mountain States Terminating CrestPoint Health Insurance Plans for Employees, Medicare Advantage”

Risk Business Requires Scale and Patience

Directional Benchmarks

Minimum population size required to ensure baseline viability of a provider-sponsored health plan

40,000-50,000

Target population size to ensure consistent profitability and market relevance of a provider-sponsored health plan

100,000+

136,336
Average enrollment in core line of business for 25 highest-performing PSHPs

10%
Average market share in core line of business for 25 top-performing PSHPs

$100M
Minimum risk-based capital for 100,000-member provider sponsored health plan

1) Based on 15.56% of anticipated annual health expenditures; assumes annual per-capita health expenditure of $5,141.

Caught in the Middle: Four-Hospital Health System Payer

Meeting Goals Around Lives Without a Focus on Market Price

<table>
<thead>
<tr>
<th>Health Plan and Value-Based Care Services Launched</th>
<th>Success Building Lives Across Multiple Products</th>
<th>High Cost, Network, Limited Change Drive Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>§ Medicare Advantage</td>
<td>§ 34,000 health plan members</td>
<td>✓ High cost position</td>
</tr>
<tr>
<td>§ Employee Plan</td>
<td>§ 25,000 ACO lives</td>
<td>✓ High unit price</td>
</tr>
<tr>
<td>§ Next Gen ACO</td>
<td>§ 6,000 physician partners</td>
<td>✓ Low performing network</td>
</tr>
<tr>
<td>§ Commercial Group</td>
<td></td>
<td>✓ No change to physician compensation</td>
</tr>
<tr>
<td>§ Commercial Exchange</td>
<td></td>
<td>✓ Leadership succession</td>
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Positive impact on cost and quality for health plan members
**The Market GDP is Much Broader than Inpatient / Physicians Segments**

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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>$0.04</td>
<td>$0.10</td>
<td>$0.14</td>
<td>$0.20</td>
<td>$0.20</td>
<td>$0.32</td>
<td></td>
</tr>
</tbody>
</table>

Providers are uniquely positioned to influence and drive value across full continuum
- Full view of patient clinically for targeted interventions
- Deep clinical knowledge: pathways and protocols
- An engaged physician network
- Relationship-based patient engagement

1. Med tech
2. Drugs
3. Admin Costs / Others
4. Post-Acute Care / Other Care
5. Outpatient Care
6. Hospital Care

Competition for Physician Assets Heating Up

Physicians Have Growing Number of Alternatives to Hospital Employment

Four Main Alternatives to Health System Employment

1. **Large Independent Groups**
   - **25%** Growth in median medical group size, 2013-2015
   - Physicians currently part of a group of 100 or more

2. **National Practice Companies**
   - **$400M** Venture investment in Privia for care delivery innovation, primary care expansion, 2016

3. **Private Equity Firms**
   - **3-5 years** Common investment duration for private equity firm
   - **$250M** Invested by equity firm Summit Partners in DuPage Medical Group, a 459 physician multi-specialty group in Illinois

4. **Health Plans**
   - **75** Markets for which United subsidiary Optum aims to provide primary care and ambulatory services
   - **40%** Surveyed independent groups who reported interest in acquisition by health plans

Providers: Intermountain Leverages Care Platform for Growth

Success Demands Systemness in Multiple Dimensions

Care Management Strengths

- Physician-led guidance councils establish and incentivize clinical standardization best practices
- Membership mentality emphasizes building patient relationships
- Retail clinics, telehealth prioritize access and convenience

1. **Build** an integrated system-level care variation reduction organization
2. **Align** physicians and clinical stakeholders on the care reliability ambition
3. **Design** new care standards and pathways that clinicians trust
4. **Embed** standards at the point of care with EHR enablement and training
5. **Measure** adherence and outcomes to surface variation and track impact

SUSTAIN: 4% CAP ON PREMIUM INCREASES

Across all five domains of the care variation reduction strategy, clinical leaders must sustain continuous improvement through systems and values that promote engagement, collaboration and organizational learning.

Why Should We Be Encouraged?
Revenue Strategy: Go It Alone v. Payer Partnerships

Go It Alone

Single System / Product Partnership

Provider Consortium

Delegated Risk / Narrow Network

Mixed Experience with Payer Partnerships Due to Differing Strategic Objectives
# The Provider Advantage: ACO Performance Improving

## Total ACO Participation and Performance, 2014-2016*

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Participating ACOs</td>
<td>353</td>
<td>404</td>
<td>484</td>
<td>↑ 20%</td>
</tr>
<tr>
<td>Net Savings Relative to Benchmark</td>
<td>$411M</td>
<td>$466M</td>
<td>$761M</td>
<td>↑ 63%</td>
</tr>
<tr>
<td>Total Bonuses Paid</td>
<td>$423M</td>
<td>$684M</td>
<td>$796M</td>
<td>↑ 16%</td>
</tr>
<tr>
<td>Net Results to CMS</td>
<td>($2.6M)</td>
<td>($216M)</td>
<td>($5.2M)</td>
<td>↑ 98%</td>
</tr>
</tbody>
</table>

*Includes participants in the Medicare Shared Savings Program, Pioneer ACO Model, and Next Generation ACO Model. Next Generation ACO Model was not available until 2016.

## Key Learnings

- **Improvements in financial performance** outpacing increases in participation
- **Experience matters; first-time participants** less likely to earn savings
- Those in **downside models** more likely to generate savings

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Capturing Value: Deal Terms Critical for Monetizing Savings

Sampling of CMS ACO Settlements* (in millions)

- ACO #1: 17
- ACO #2: 15.7
- ACO #3: 6.9
- ACO #4: 6.5
- ACO #5: 6.0
- ACO #6: 2.3
- ACO #7: -2.8
- ACO #8: -2.8
- ACO #9: -7.6
- ACO #10: -11.9

*Anticipated 2017 shared savings data, according to Evolent analysis

- Strong clinical performance can be outweighed by benchmark and deal terms
- Critical that risk score matches severity of the population
- Shifting deal terms can lead to further deterioration
Capturing Value: Network Design and Pricing are Critical

Figure 1. Average Payment
Cardiac Imaging Episodes (Risk Adjusted)

- **Office**: $655
- **Hospital Outpatient Dept. (HOPD)**:
  - 3 Day Episodes: $2,072
  - 22 Day Episodes: $2,862
  - Risk Adjusted: $5,148

Figure 2. Average Payment
22-Day Colonoscopy Episode (Risk Adjusted)

- **Office**: $1,322
- **ASC**: $1,435
- **HOPD**: $1,784

Note: 95% confidence intervals of estimated average unadjusted and risk adjusted payments not shown in Figures 1 and 2.

## What We’ve Learned: All Elements Matter

<table>
<thead>
<tr>
<th>Corporate</th>
<th>Middle Office</th>
<th>Front Office</th>
<th>Back Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Analytics</td>
<td>Legal and Compliance</td>
<td>Provider Data Mgmt</td>
<td>CM, DM, UM</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>Human Resources</td>
<td>Network Mgmt</td>
<td>PBM</td>
</tr>
<tr>
<td>Finance / Accounting</td>
<td>General Ledger</td>
<td>Pop Health Analytics / Quality</td>
<td>Contracting</td>
</tr>
<tr>
<td>Core Platform</td>
<td>Actuarial</td>
<td>Behavioral Health</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>IT Support</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key Metrics

- **$2.5B**: Claims processed in 2017
- **~3.5M**: Lives supported
- **~90**: Unique lines of business
Half of Medical Expense is Driven by a Small Proportion of the Population, Requiring a Targeted and Fully Integrated Approach to Drive Clinical Value

*Based on 2016-2017 Evolent Medicare Book of Business
Predictive Identification: Using Machine Learning to Catch Members Before an “Impactable” Adverse Event

Over 50 Unique Machine Learning Models Predicting 20 Different Adverse Outcomes Across 3 Populations
Predictive Identification: Real-time Data Dramatically Reduces Time to Outreach to Avoid Hospital Admissions

Claims-based Stratification
- ED visit, Primary Dx: CKD Stg 4
- Admission for Edema
- Community Health Worker (CHW) Outreach

Real-time Stratification
- ED visit for swelling, shortness of breath; GFR<30
- CHW Outreach
- PCP office visit; start on Lasix; refer to nephrologist
- Admission Avoided

60-90-day Claims Lag
24 Hours
By analyzing all prior Identifi™ cases, we know which specific program and activities are most strongly correlated with positive health outcomes for a given case.

**Performance Management: Continuously Monitor Completion of Highest Impact Activities of Care Team**

**COMPLEX CARE PROGRAM**

- Arrange for low-sodium meal delivery and transportation to PCP and nephrologist office visits
  - CHW

- Perform comprehensive clinical assessment, develop integrated care and symptom response plan
  - RN

- PCP prescribes meds (Lasix), titrates other medications, refers to nephrologist
  - PCP
Capturing Value: Physician Alignment and Engagement is Critical

Creating a High Value Network around Low Cost and High Quality Facilities...

...With WakeMed at the Center, Working with PCPs to Realize Value from the Network

WKCC Building Operational Capabilities:
- Select high value, low cost partners
- Integrate data, process and results
- Develop payer-specific products and new payment models

PCPs Utilizing Value Infrastructure to:
- Coordinate care
- Manage workflow and data across payers
- Participate in clinical savings pools

~220K Lives
$20M Reduction in cost to payer in 2016
6 Lines of business

## Impressive Impact on Avoidable Spend for Patients Managed in Evolent Health’s Care Programs*

*Derived from client data collected from 2014-2018; exact study period varies because it is dependent on partner onboarding dates. External validation of Evolent’s clinical model and methodology completed by the Care Innovations Validation Institute in 2016.

### Care Model Externally Validated by the Care Innovations Validation Institute

<table>
<thead>
<tr>
<th></th>
<th>Total Medical Expense</th>
<th>Inpatient Admissions</th>
<th>ED Visits</th>
<th>PCP Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>▼ 24%</td>
<td>▼ 38%</td>
<td>▼ 51%</td>
<td>▲ 7%</td>
</tr>
<tr>
<td>Next Generation</td>
<td>▼ 48%</td>
<td>▼ 66%</td>
<td>▼ 51%</td>
<td>▲ 7%</td>
</tr>
<tr>
<td>Medicare ACO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Health Plan</td>
<td>▼ 21%</td>
<td>▼ 33%</td>
<td>▼ 36%</td>
<td>▲ 7%</td>
</tr>
</tbody>
</table>

*Medicare Advantage
*Next Generation Medicare ACO

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Six-Facility Health System Building a Platform for Growth and Performance Management

• Launched MSSP Track 1 in 2012
• Entered into partnership with Evolent Health in 2015 to manage risk contracts

**EFFORTS**

Next Gen ACO, Humana, employees
Clinical transformation and integration

**IMPACTS**

Top 4 performing Next Gen ACO in 2016*
Anticipated $10M+ in shared savings across 2016 & 2017**
48% reduction in medical spend from complex care***

Regional leadership in value-based care

*Based on CMMI Medicare Next Generation Accountable Care Organization Model Performance Year 1 (2016) Results
**Based on CMMI Medicare Next Generation Accountable Care Organization Model Performance Year 1 (2016) and Year 2 (2017) Results
***Based on EVH case controlled study
Provider-Owned Medicaid Health Plan: A Community-Based Advantage

<table>
<thead>
<tr>
<th>Provider-Based Organization</th>
<th>Depth of Knowledge on Local Population</th>
<th>Social Determinants of Health</th>
<th>Integration with Providers &amp; Community</th>
</tr>
</thead>
</table>

Partnering with Community-Based Organizations

Provider-Owned Medicaid Health Plan: Performance Improvement and Innovation

A recognized leader in provider-led Medicaid for 20 years partnered with Evolent in 2016 to increase efficiency, effectiveness and quality of care for both providers and members.

<table>
<thead>
<tr>
<th>~$79M+</th>
<th>300K</th>
<th>★★★★★</th>
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</thead>
<tbody>
<tr>
<td>Savings from Medical Expense Initiatives</td>
<td>Members served by this health plan</td>
<td>Satisfaction with health plan services NCQA ranking</td>
</tr>
</tbody>
</table>

Year over year performance impact:

<table>
<thead>
<tr>
<th>2016 MLR before savings*</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.9%</td>
<td>-0.3%</td>
<td>93.9%</td>
</tr>
<tr>
<td>-0.3%</td>
<td>1.5%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>-1.4%</td>
<td>-1.4%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>2016 MLR**</td>
<td>93.9%</td>
<td>91.3%</td>
</tr>
</tbody>
</table>

* 2016 MLR before savings is estimated off of final 2016 financial results and estimated savings.

** 2016 and 2017 MLR based on their respective December financial statements, adjusted for medical expense restatements through January 31, 2018.

A recognized leader in provider-led Medicaid for 20 years partnered with Evolent in 2016 to increase efficiency, effectiveness and quality of care for both providers and members.
Adapting Stanford CERC’s Chronic Kidney Disease (CKD) Model for this Health System’s Community

- Successful pilot identifying and intervening with Chronic Kidney Disease Stages 4 and 5 patients
- Educated physician network on nephrology referrals
- Rolled out to 25 of 31 practices
- Expanding to additional practices in the network
- Innovating and iterating the program to now include wider net for CKD Stage 3
- Looking to apply methodology to other clinical areas

Source: http://www.dacbond.com/dacContent/doc.jsp?id=0900bbc78021c75a
Physician IPA: A New Entrant Also Making Its Mark

Imperatives for Health Organizations

Higher Value. Bring down both unit cost and total cost of care

- High performing ACO
- Unprecedented engagement
- Advancing to Level 3 of VBP

Improve Delivery Model. Make care more convenient and consumer-focused

- Care delivered in native language
- Hyper-local approach to address SDoH
- 3,500+ providers in 4 NY boroughs

Upgrade Infrastructure. Use scale to improve and expand asset base

- Improved care programs
- IdentifiSM workflow & analytics
- Growing footprint to 1M patients

“A 5-year vision to create a multi-cultural, multi-lingual integrated medical delivery system, created for the fastest growing minority community in the United States”
UPMC: Building a Sustainable and Differentiated Value Strategy

Integrated Delivery and Financing System

- Cutting edge analytics and clinical insights
- Integration across the episode of care
- Physician engagement → Clinical transformation
- Proactive engagement across multiple modalities
- Consumer v. Patient

<table>
<thead>
<tr>
<th>Commercial Products</th>
<th>Medicare Products</th>
<th>Medicaid Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>$16B</td>
<td>5.8K</td>
<td>471K+</td>
</tr>
<tr>
<td>Operating revenue</td>
<td>Affiliated physicians</td>
<td>Commercial lives</td>
</tr>
<tr>
<td>187K+</td>
<td>MA / Medicare lives</td>
<td></td>
</tr>
<tr>
<td>1.5M+</td>
<td>Medicaid lives</td>
<td></td>
</tr>
</tbody>
</table>

Leveraging Provider Advantage to Create Sustainable Differentiation

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Insights from Outside Our Industry

System Thinking Necessary to Drive Transformational Change

Practice & Repetition
Make Perfect

Revisionist History
We Behave in Conflict with Data in Front of Us

How Do Davids Triumph?

Leveraging Mavens, Connectors, Salespeople
Health Care’s Latest Disruptor?

New Employer Coalition Takes Aim at Health Care Costs

“The ballooning costs of healthcare act as a hungry tapeworm on the American economy...we share the belief that putting our collective resources behind the country’s best talent can, in time, check the rise in health costs while concurrently enhancing patient satisfaction and outcomes.”

Warren Buffett
Berkshire Hathaway Chairman and CEO

PRESS RELEASE: Amazon, Berkshire Hathaway and JPMorgan Chase & Co. to partner on U.S. employee healthcare

“The three companies, which bring their scale and complementary expertise to this long-term effort, will pursue this objective through an independent company that is free from profit-making incentives and constraints. The initial focus of the new company will be on technology solutions that will provide U.S. employees and their families with simplified, high-quality and transparent healthcare at a reasonable cost.”

Business Wire
