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Agilon Health, Inc. (AGL)

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MANAGEMENT DISCUSSION SECTION

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Good morning. My name is Lisa Gill. And I'm the health care services analyst with JPMorgan. It is with great pleasure this morning that I have Agilon Health. With us this morning, we have CEO, Steve Sell; as well as CFO, Tim Bensley; as well as IR, Matt Gillmor. There will be a Q&A session at the end, but I'm going to turn it over to Steve to start the presentation. Thanks very much, guys.

Steven J. Sell

President, Chief Executive Officer & Director, Agilon Health, Inc.

Great. Thanks, Lisa. It's great to be here. I want to do a few things this morning. One, give context on our business; two, talk about structural factors that are really driving the acceleration of value-based care in the senior patient markets; three, share a case study from our Akron markets in which we've just finished year three and show the investments that we've made there and the outcomes which are really remarkable; and then give a business update, including some observations on the future.

So, if we go to slide 3, context, our vision is to transform health care at the community level. We do that by partnering with leading community-based physician organizations who've been in their communities for decades. And we transition their existing Medicare patients from fee-for-service to a full risk total care model in which the primary care physician is responsible for the total cost, quality, and experience.

We do that by providing them with a platform of capabilities that enables that move in success and a partnership that totally aligns physician economics with desired patient outcomes. The results show the power of the model. We now have 16 anchor partners in 17 diverse geographies. And as of this month, 300,000 total members on the Agilon platform in full risk with net promoter scores that are better than that of Apple and Southwest Airlines.

In terms of investment highlights, these are some real distinguishing facts for Agilon. We're going after a very large growing addressable market, and the move to value is only enhancing that. We like to be first, and there's a

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real first-mover advantage as we move communities from fee-for-service to risk for the first time and that gives us advantages in terms of cost, quality and experience. We have a great alignment with our local physician leaders who've been in their communities for decades and we're able to drive outcome. Our platform allows us to unlock diverse geographies and partner types.

Perhaps most importantly, physicians are winning in really meaningful ways. They're able to practice medicine the way they were trained to. They're able to invest in their patients, care more fully, and they're reaping the rewards from a personal financial perspective. And finally, our growth model is capital-light and incredibly efficient.

Going to the next slide. There are significant structural changes that are defining the future of value-based care. The senior population is growing. 10,000 people a day are turning age 65. That's increasing demands. 25% of health care spend is estimated as waste and is there to be managed out. The largest purchasers in health care, CMS and health payers are looking at the move to value as the number one solution to help manage out that waste and drive lower costs.

In fact, the Innovation Center, with their recent 10-year strategy paper, has laid out a goal by 2030 of all Medicare beneficiaries being in a total care model relationship, which is an incremental 30 million senior patients that would move to value-based care. But the challenge is primary care physicians are not ready for that. Everyone identifies them as a key to the solution, but they don't have the time. They're working a lot of administrative things and they're losing money on their Medicare businesses today. They need more support.

And so, our solution is that we've created a new category. We call it high value primary care. It takes the primary care physician and it moves them to that most important position that you see in the upper right in which they can play that total care quarterback role. We surround them with care teams and we surround them with actionable information to make that possible.

We're able to do that as we go to the next slide by providing them with the Agilon total care model. Our total care model is expressly focused on the over 65 population and expressly focused on value. There are three elements. The platform that brings technology, people, process and capital, and it allows that move from fee-for-service to value. It has been built with doctors and for doctors. The partnership that creates that alignment of physician economics with patient economic outcomes and takes advantage of the unique proximity that we have by being co-located with primary care physicians.

And then finally, as we grow communities and doctors, we grow our network. We now have a national network of likeminded entrepreneurial physicians, and they're sharing best practices and driving innovation faster.

Go to the next slide. Our purpose-built platform really enables the move to value at scale. It allows us to move these practices from fee-for-service to value for their senior patients. And it allows us to execute consistently across the country with a diverse set of payers. We're able to bring the critical elements of value-based care like payer engagement, clinical programs elements of value-based care like payer engagement, clinical programs and quality, and execute those consistently across markets. That requires a technology engine that is flexible and agile and has the ability to be payer agnostic, EMR agnostic and pull data and provide insights regardless of the source of that data.

We believe that our platform is increasingly a source of competitive differentiation. Our partnership – go on back, Matt. Our partnership is [ph] splitting (00:06:31) Medicare to a single risk line of business. And it's taking practices from the status quo on the left, in which their senior patients are in an uncoordinated and fragmented experience, driven by payers with different expectations around incentive programs and quality programs to an integrated total

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care model that's built around that primary care physician and places them at the center. It provides for a single experience for patients, for the front-office staff, for the physicians, regardless of who that payer is, whether it's CMS through direct contracting or Aetna or Anthem or Blue Cross. And it allows for far better coordinated care and outcomes.

We believe there is a very powerful flywheel to value, and we are starting to see that as we go deeper in these communities and as we grow more fully across the country. What we're seeing is that as docs join our common platform and improve patient outcomes, that is creating incremental economics for that local system and for the doctors. As more doctors and groups join, our network grows and we have better data insights. That, too, improves outcomes. As outcomes improve and there's more dollars to invest, we're able to invest more outside the walls of the primary care practice, increasing touchpoints for seniors where the majority of spend actually occurs.

And then finally, as more docs join, it keeps accelerating and we're seeing this virtual effect. The virtuous cycle expands patient access. We're able to increase the frequency and breadth of senior patient touchpoints both within the office and outside of the office.

We have found our partners opening panels to Medicare patients that were previously closed. We are increasing patient touchpoints and importantly we are stratifying those highest risk patients that benefit the most from increased interaction with their primary care physician. Outside the office, we're investing in ED diversion programs, pre-discharge programs that make sure that that senior patients go into the most appropriate post-discharge setting and targeted clinical programs like specialist referrals and end-of-life palliative care.

And so, this is the Akron case study that I talked about at the beginning which really sort of brings this together. I'm now on slide 12. What you see is what Akron looked like in 2018 when we started. That was our implementation year. Our partner in that market, Pioneer, exceptional group, really strong relationships with their patients. But that relationship was really a one-on-one relationship and largely confined to what occurred within that primary care setting. Once the patient moved out of that setting, there was poor coordination and limited data visibility.

What we've been able to do across three years is invest substantially. We placed that primary care physician and the patient at the very center. We've surrounded them with a care team of social workers and nurse practitioners and pharmacists, and provided them with actionable data insights. When that primary care physician wants to send a patient to a specialist, they have a specialty referral team that made sure that, that patient gets to the highest quality, top tier specialist in that category. And then our technology and our platform closes the loop. We know when that appointment has been scheduled. We know when it occurs and what happened during that visit.

Similarly, within hospitals, we've been able to invest and have nurses within the ER as senior patients go in, there's an opportunity to have a dialogue and say, is this something that needs to go to the hospital? Is this something that could be delivered at home with the support of a care team? And also at that pre-discharge level in terms of managing overall post-acute.

And so what have been the results in that market? It has been a dramatic improvement. 48% more touch points for high-risk patients, 70% referral rate to Tier 1 cardiologists. And each time we're referring to a Tier 1 cardiologist, we're saving on average $100 per member per month for that cardiology patient. And that has resulted in that economics that we talked about in the flywheel for the system, and for the physician. An incremental $150,000 distribution to PCPs in 2020, as a result.

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That has allowed us to invest. That has allowed us to grow. We've gone from 8,000 patients in 2019 up to 18,000 at the end of 2021. And we know that, that number is going to grow quite a bit more in 2022. And from a medical margin PMPM perspective, we've been able margin PMPM perspective, we've been able to grow from $40 PMPM in 2019 to $160 per member per month in 2021 on a preliminary basis. That's ahead of where we would expect a year three market to be and tracks very well.

We're doing this nationally. We're doing it in 17 communities, and we're able to improve patient experience and outcomes. In the middle of the page, we show you five-star performance from a HEDIS and STARS perspective. 90% adherence to medications for cholesterol, hypertension, diabetes; and 82% screen rate for breast and colorectal cancers. We're also reducing in-patient visits, reducing readmission rates. And in a limited number of geographies, we're starting to dramatically reduce the total spend for end of life care. All of that is made possible by expanding access, both within that primary care office where we've got increased touchpoints, and with those critical high-risk patients both in and outside of that office, and our patients are incredibly satisfied with that.

We're doing this nationally. We're doing it in 8 states and 17 communities. And as we announced, the class of 2023 at our Investor Day, we'll expand that nicely. And it's a diverse set of geographies and partners, multi-specialty, primary care only, rural, metro, single-TIN entities and multi-TIN, multi-EMR entities. And we're able to be successful in diverse geographies as Pinehurst which is small and a high growth market, and Buffalo which is larger and in a lower growth market. But in both places, we're performing quite well. We have a highly actionable addressable market, 20 million Medicare beneficiaries with $250 million in annual spending by 2025. It's in front of us. And we have a very effective method to go after them.

If you go to the next slide then. We have a very predictable and highly visible growth algorithm. We grow in new geographies and we grow in the same geographies. In new geographies, every time we enter a new state like we've entered Michigan for 2022 that opens up that entire state. We're then able to add in other communities within that state, as you see in Texas, where we've got three communities.

Once we're in a geography, we're able to consistently deliver growth rates in the low to mid-teens. That comes both from an organic perspective of patients in the practice, moving into a full risk relationship through Medicare Advantage with direct contracting and adding additional physicians and that's a function of that first-mover advantage. Once we've set up that platform, once we're in a community, we become the preferred approach for physicians to move into to value-based care.

I'm going to skip over the case study and just briefly highlight that we have a really highly attractive acquisition model. The LTV to CAC dynamics are incredibly strong. We start with a low cost of acquisition, $400 per member and go down from there. By generating medical margins like you see here, and this is Akron again, just as an example, to pay that back within one to two years. We're able to continue to add patients and the return on investment is compelling. And that gives us just tremendous momentum in the business. We're able to grow markets, we're able to grow members and we're able to grow medical margin and you can see the CAGRs that are here.

And Lisa, I thought I'd close with a January business update. Looking back at 2021, looking ahead at 2022, when you talk about 2021, you perhaps have to start with COVID. I am so proud of our team and our partners and the job we've done to manage through multiple surges throughout 2021.

I think our high touch primary care model really distinguishes us. We've been able to manage costs and deliver predictable results through each one of these surges. We've been able to maintain those touch points, and so we don't see the volatility in our RAF that perhaps you do in other models. In terms of this most recent surge, we're

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only seeing modest COVID-related inpatient utilization. We are seeing continued suppressed non-COVID inpatient utilization, but that's partially offset by a shift from inpatient to outpatient that we've been seeing for a while.

When we talk about membership and margins, we're finishing the year in a very strong position. We're not reporting our Q4 results day, so I don't want to get out over our skis, but I think we're comfortable saying that we're ending the year with an incredible growth rate, 40% – greater than 40% growth in Medicare Advantage membership, a really strong same geography growth rate. Our medical margins, like we showed in that Akron case study, are progressing very nicely in our 16 partner markets. That represents about 85% of our Medicare Advantage membership.

As we go deeper in these communities, as we add direct contracting, we're finding tremendous leverage in our platform support costs, and we're consistently running below what we initially had forecasted for it. And then finally, we're really proud that this year we added Direct Contracting. It's a new government program. We're seeing the benefits of MA and Direct Contracting together, and we've consistently been able to deliver medical costs and RAF that are in line or better than our expectations. We are sharing that we now are expecting that Direct Contracting will move from a modest adjusted EBITDA gain to a modest adjusted EBITDA loss based on updates from the Innovation Center around what's called a retro trend adjustment.

But all in, a very successful year. We're closing very well and we're entering 2022 and taking off. We've had a great start to this year, an extremely strong AEP period driven by, again, 90%-plus retention. That's a function of our multi-payer model that allows us to really – a patient can move from one health plan to another, but they stay with their physician, and strong sales. We've done a very good job onboarding six new markets with 50,000 MA patients and added another 30,000 Direct Contracting patients, and we now have Direct Contracting, MA in 10 of our 17 markets. And we did reaffirm with an 8-K this morning our confidence in a very strong growth rate for 2022. And we're forecasting positive adjusted EBITDA for 2022. We will give a full forecast on our Q4 call. This is really being driven by maturing partner, market medical margins like we saw in that Akron case study in 2021 and improvement in Direct Contracting and in our non-partner market of Hawaii.

Let me close with just a few observations and what we see for the year ahead. I think the structural factors that I talked about at the top cannot be overstated. There is going to be a dramatic increase in the depth of demand for primary care centric value-based care for seniors. Doctors are eager to make the move from fee for service into value-based care, and they need a partner to do it. Health plans are feeling the pressure from a quality expectation, experience expectation and aggressively trying to move patients. And CMMI has really laid down the marker with their 10-year vision of 30 million incremental patients moving into value-based care.

The breadth of demand is going to continue to expand as the diversity of our partners, the diversity of payers and the diversity of geographies grows. We're reaching critical mass locally and nationally. As we go deep, we're seeing the ability to impact costs outside the walls of the primary care office like we showed in that Akron case study, and we're finding new partners in new geographies who are saying we need a partner and we'd like to grow with Agilon.

Finally, the quality of our economic model has allowed us and will continue to allow us to deliver predictable results in periods of volatility. No one can predict exactly what the future is with this pandemic, but we know that we can deliver predictable results. New government programs evolve over time, but we can deliver predictable results.

And so, with that, Lisa, I think we can go to Q&A.

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QUESTION AND ANSWER SECTION

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

All right. Thank you so much for all the commentary, Steven. It was really helpful. Let me just start, though. When we think about a number of these physician enablement companies that have come to the marketplace, especially here in 2021 or last year in 2021, can you maybe just talk about a couple of things? One would be the differentiation of your model; two, the key strengths of a partnership model, and then; thirdly, I'm sitting here and I'm with a group of doctors, why don't I just take on the risk myself and cut out the middleman?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Yeah. Well, there's a lot in that question and it's a good one. I mean, I think there is a broad definition around enablement, but I think what's really distinctive about our model and what I tried to say in my remarks is that we're working with existing physicians, Lisa. And in a partnership model, we're moving them from fee for service to value in their existing patients.

Everything we do from our technology, from our platform, from our partnership is oriented around that. We're able to take them from a transactional relationship into one that's built around a subscriber relationship. There are real distinguishing factors that come in that partnership model. There's advantages in terms of the predictability of what we're able to do. There's that first mover advantage we pride ourselves on going in communities and being able to move people for the first time.

There's an incredibly low cost of acquisition that we have as we grow in those communities. And as I said, we're able to enter at scale, which is different from a clinical model or someone who's selling technology services. And that allows us to impact those costs, which I tried to emphasize outside of the office. I think those are key elements to that partnership model and why it resonates. And as we do this in more markets, the reference from our other partners is bringing in additional partners and additional physicians within those communities. So, the growth model, the economic model are all a function of that.

And then why would a large group say, hey, I could do this on my own versus doing it with a partner like Agilon, I think start with Bill Wulf in Central Ohio Primary Care. Bill is the CEO. They're the largest independent primary care group in the country. Bill is the Chair of America's Physician Groups, incredibly well-respected.

But he concluded that they needed a partner. They didn't have the technology that they needed to be able to deliver and risk. They didn't have the ability to invest ahead of the outcome, and they didn't have the expertise that was required to make that all possible. And so, the combination of those things, I think, is what led Bill to make that decision and what we're seeing with others.

And then the track record, right. If people were wondering about it, I think the track record that Agilon has now with partners in 17 communities really speaks to our ability to deliver results to do it in a set of diverse geographies. But we always try to find one or two partners that closely mirror a new partner that will be coming on.

So, Pinehurst is an example in North Carolina. The Wilmington team has worked very closely with them on their implementation. Syracuse, which went live just last week, work very closely with the Pittsburgh team because of

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the similarities in those markets, the similarity of senior patients, payer types, whatever it is. And so, that flywheel that I talked about, I think, is allowing that acceleration.

And the last thing I'll say is if we're going to get to 30 million incremental senior patients on full risk value-based care, you're going to need a partnership and platform model that's going to be able to move hundreds of communities that are full fee-for-service today into full risk.

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

And have them look similar, right?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

And have them look similar. That's right. Those components that I talked about, they're executed the same way whether you're in Austin, Texas or in Toledo, Ohio, whether you're in a multi-specialty group or you're in a primary care group, whether you're 25 primary care physicians or 100-plus primary care physicians,

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

The other question that we get, Steve, is just that you're in some markets that we would consider somewhat non-traditional Medicare markets, right. Like so, most people think, oh, I'm going to go into Medicare Advantage, I'm going to go down to Florida, or I'm going to go out to Southern California or Arizona. Can you maybe just talk a little bit about targeting the MA markets that you have, number one?

And number two, there's a lot of different players that are trying to work with physicians today. Do you still see a lot of opportunities with physicians that are still looking for partners in the marketplace, or do you feel that it's a little bit more competitive today than it was a few years ago when you got started?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Again, a lot in that question, I mean. So, I think there's more capital and I think there's more players in the space. I think, Lisa, we have a pretty unique value proposition, and the folks who are talking to us are typically, in terms of new partners, are not necessarily looking at others. The place, perhaps, where we see competition is once we're in a geography, a smaller practice that might historically have thought about selling to an Optum or hospital system is now coming to us.

And that's why I said, we are becoming that preferred vehicle in the communities we're in for independent docs that want to move to value based care to come on that platform. And so, that's a big part of it. But why do we choose the communities that we do? We like being that first mover. We like moving the entire community from fee-for-service to risk. There are hundreds of communities out there, maybe thousands that are still at that fee-for-service level. But are – that TAM that I showed you is really built around those communities, those groups that we could build around and what sits there.

And the advantages of doing that are significant from that scale perspective we're able to go in, once we're able to build that ecosystem that technology and platform view that I showed connecting hospital systems, connecting specialists, having that closed loop back to that primary care physician.

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Once that's implemented, it's very difficult to unseat. Investors ask us about our moat that is a very powerful moat. And so, the idea of going in having critical mass, moving a market, patients, physicians into full risk value-based care for the first time is something that we're pretty excited about. I think we're doing pretty well with that.

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

And I've seen that you talked about this in other presentations when you talk about the profitability of that member over time, right. And managing that that patient and getting to that $160. But can you maybe just help me and investors understand kind of like the time line of how that works, right? So, each year, is it simply that patient was somewhat unmanaged or wasn't seeing the right specialist or wasn't doing things from a wellness perspective? How do I think about how that patient is better managed to be able to get to those economics?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Yeah. I mean, I think that is a progression in terms is a progression in terms of what we're implementing with these groups that help drive that medical margin progression. I think we've said we're comfortable as long as we have alignment with the partner that perhaps they'll start in different places, but that we can drive that improvement over time.

The Akron example I showed is accelerating ahead of where we would expect that to be, and that's really a function of very strong alignment and our ability to invest outside of that primary care office and the scale that we've got there.

But what does that look like? In year one we really want to operationalize the model, which means the team is in there and the basics of value-based care, getting people in for a structured wellness visits are really important and increasing the number of touch points.

We spent a lot of time in that first year and even in implementation identifying where the cost opportunities are [indiscernible] (00:30:33) potential particular specialty, is there a readmission issue across the market, is that at a certain facility, because that's going to allow where you're going to be able to make those investments and really impact that.

And the last thing is there's a lot of learning in that first year. We use the network to feed and those references that I talk from other markets about what might this plan look like. Then as we move to year two, we really start saying we've got years' worth of data. How are we going to reduce the variability among the physicians that are within that group? How do you reduce variability among the pods that sit within that group and we begin to invest, we begin to improve processes. We're looking at those care points outside of that primary care office because in that first year that care team is pretty strong within the office. And then in year two, we began to invest in growth.

So, the case study that I showed as we began to ramp up, whether that's practice acquisitions that our partner is going to be making, whether it's residents that are coming into primary care for the first time, whether it's smaller groups who decide to join in to that partnership, there is a conscious effort with them because value-based care is benefits from scale. And so growing and starting with a critical mass and growing that gives you huge value over time. And we're so early in our cycle, but we're already starting to see the benefits of that scale. So that's what that progression looks like. That's how you're able to drive to that $150 to $200 that we talk about by year five.

Obviously, there are markets like Akron that are tracking well ahead of that. And I think when we show you on Investor Day, you're going to see a very nice cohort progression across our partner markets.

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Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

Now, when we think about utilization, you touched a little bit on as we think about COVID, right, and as we think about that modest inpatient utilization. And I think you made the comment that it's being offset right now by utilization on the other side. So should we think that there's any pent-up demand around things like elective surgeries as we go into 2022?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Yeah. So, we did see some bumps in the back half of 2021 in terms of some discretionary surgeries. I don't know that we believe there's a massive set of pent-up demand, particularly in our model because we've got those touch points and we've been working very closely with those senior patients, particularly those high-risk patients. That's why that 50% increase in terms of touches with those patients yields such positive results. But the shift from inpatient to outpatient, I think that's systemic. I don't think that's just Agilon. I think that you are going to see that in larger ways. And I think that's a positive for the overall health care system, but it does mean where we invest and how we use our platform to keep the primary care doctor in the loop evolves.

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

And we talked a little bit up here about margins, but maybe we can talk about long-term margin targets. You talked about today in the presentation, but you've also talked historically about EBIT – adjusted EBITDA profitability in 2022. But how do we think about, one, your long-term margin target; and, two, how you get there over time? Like, what are going to be the key things that we'll be looking out for?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Yeah. So we've talked about a – and, Tim, you can jump in here, but we've talked about long-term adjusted EBITDA target in the low double digits. The way we get there is that we're ultimately able to provide medical margins that are in the 25% range. We do sharing and we back off our platform support costs and that's what gets us to that level.

What makes that possible? I think you start with the core ingredients of alignment that you have with those physicians. I think you start with touchpoints in the primary care office. I think you stratify your high-risk patients. Those are the patients that have the greatest amount of costs and the greatest opportunity to manage them. But you need to really be all over them, not just with the primary care doctor, but that entire care team. And then it's going after those big cost sets, right, specialty costs and what's happening within inpatient facilities.

And so, the investments that I talked about that we showed in that case study, ED diversion, having nurses at that point of intersection and reducing the amount of folks that are going into inpatient, that pre-discharge planning and getting the person to the right place, getting a 48-hour follow up with their primary care doctor after their discharge has a dramatic impact on reducing readmission rates. And so, it's a combination of those things, Lisa, that I think drives that. And, I mean, Tim, would you add anything to what I said?

Timothy S. Bensley
Chief Financial Officer, Agilon Health, Inc.

A

Just super quick, Steve. The only thing that I would say is that we – I don't like to ever talk about our margin progression without saying there's just one component of what is really a compelling economic return story for us

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that Steve talked about in the example where we have a very low cost of acquisition. We obviously are generating this positive medical margin, positive market EBITDA pretty quickly.

On that very, very low cost of acquisition, I mean, we're getting paybacks in like the one- to two-year range. And the returns on our members that are typically on the platform for 7 to 10 years is really tremendous. That margin part is a big part of it.

Just real quick to fill in some of the gaps for anybody who's trying to do the math, if we're looking at an $850 or so revenue PMPM and we're going to generate $200 long term of margin PMPM, that's that 24% – 23%, 24% that Steve was talking about.

Approximately split that in half, so say we're looking at 11% to 12% flowing through to Agilon. We expect over time that we're going to continue to get scale as we have been this year out of our platform support costs, and it will reduce to, say, 2% to 3% of G&A coming off that number. But again, we're pretty confident and excited about the DCE program and expect that that'll generate, say, 1% to 2% of margins over time or contribution to 1% to 2% on margins over – or contribution to EBITDA margins over time, and that kind of gets you to that double-digit math.

And we showed you some examples. We certainly have markets that are getting there already today. And within markets, our more mature cohorts are already getting to that above $200, and we're going to come back in Investor Day and actually go deeper into those cohorts.

You can see that progression, but very encouraged by those earlier cohorts that, of course, are not affected by the dilution of new members coming on, already getting over that $200 medical margin PMPM level.

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

[ph] And Steve (00:38:00) updated ever so slightly direct contracting, previously, it was slightly profitable. Now, it's slightly dilutive to – or a slight loss on the numbers. Can you maybe just talk about kind of what's going on in that book of business and your expectations kind of going into next year?

Steven J. Sell
President, Chief Executive Officer & Director, Agilon Health, Inc.

A

Sure. Yeah, I mean, again, strategically, we think direct contracting is super important for us. Our partners are seeing the benefits of that scale they've got within their practice and the scale they've got within their community. And we're seeing it in the results of MA and Direct Contracting. We've got our medical costs coming in at or below what we expected in our raft, similarly at or above the performance level that we laid out.

The update of moving from modest positive to modest negative from an adjusted EBITDA perspective is really based on the update from the Innovation Center in terms of how we get paid, which is a benchmark. And there's something called a retro trend adjustment that's based on national trends. For 2021, it will be based on the national trends for 2020 and 2021. And the latest update that we got is that national trend will be down from what they've provided us initially from a prospective basis. And so that, that makes that adjustment. Now, a couple of points, one, it's totally manageable for us within the quarter and on a go-forward basis. But two is, the innovation center is really committed to this program.

We're great partners with them and they want to come up with a program that's sustainable and predictable and works for existing players, as well as new entrants. They've talked about a class of 2023 and I think we'd be

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growing that out here very soon. And so, we'll work with them, we'll get another update. We'll be able to update that on the Q4 call. But that's really the update in terms of what has changed. The core underlying cost and RAF continue to look very good.

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Great. But we're out of time. I wish we had more time together. I look forward to your Analyst Day in the fourth quarter, but thank you so much to the Agilon team for joining us. If you have any questions, reach out to me or anyone on my team or to Matt Gilmore in the Investor Relation. Thanks so much, guys.

Steven J. Sell

President, Chief Executive Officer & Director, Agilon Health, Inc.

Thanks, Lisa. Appreciate it.

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