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Agilon Health, Inc. (AGL)

Investor Day

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MANAGEMENT DISCUSSION SECTION

Matthew Dale Gillmor

Vice President-Investor Relations, Agilon Health, Inc.

My name is Matthew Gillmor, and I'm the Head of Investor Relations for Agilon Health. On behalf of our entire team we're really excited and thrilled to have you here for folks that are both in-person and joining us virtually. We've got a great program for you today. You're going to hear from leaders across our company are also going to hear from several our physician partners. We hope you come away with a deeper understanding of our business, why we're the trusted partner for physicians moving to value, how our platform and partnership works and ultimately how that translates into an attractive financial model for our company.

Before we begin, I do need to remind you that we will be making forward-looking statements and we'll also be referencing some non-GAAP financial measures, so we'd encourage you to read our 10-K filing with the SEC. So I wanted to walk you through the day for a couple of minutes just to get everyone oriented. We're going to start off with Steve Sell, our Chief Executive Officer. Steve is really going to lay the foundation for the day and give an overview and tell you what's to come. Veeral Desai, who's our Chief Business and Development Officer, he's going to discuss our growth strategy. He's also going to be discussing the announcement we made this morning with MaineHealth.

After Veeral, Ben Shaker, our Chief Market Officer, is going to come to the stage and talk about our platform and partnership model and really how that works every day with our physician partners. From there, we'll do a brief Q&A session with the speakers. We'll take a short break after that. When we come back, you'll hear from Girish, our Chief Technology Officer, and Dr. Dana Carne to discuss our technology platform and how that drives clinical innovation. And then really, I think one of the centerpieces for the day will be a physician panel discussion with three of our physician partners who are nice enough to be here today. So thank you. And that will be moderated by Dr. Ben Kornitzer, our Chief Medical Officer, and we'll be delighted to take questions from the group again at that time. And then finally, we'll wrap up with Heidi Hittner, our Chief Experience Officer Heidi Hittner, our Chief Experience Officer to discuss stakeholder benefits; and then Tim Bensley, our Chief Financial Officer, will bring in home with the financials; and then we'll do a third round of Q&A.

I'm going to introduce a video to you that's going to tell a little bit about Agilon, and then our CEO, Steve Sell will get us kicked off. But we really appreciate you all being here. And we hope you have a great day.

[Video Presentation] (00:02:24-00:03:58) [Video Presentation] (00:03:56-00:04:55)

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Good morning. It's so great to see all of you here, and that's such a great video to kick-off our day. It really speaks to what we do. You know, when I joined Agilon – just over two years ago, we talked about a vision of creating a really big company that could meaningfully transform healthcare at that time, I had brought two decades of experience running a large California health plan, and I'd seen firsthand the powerful impact that a primary care physician empowered as the care quarterback could have on patient and community health like you heard in that video. Today, we're going to give you a very encouraging progress report about our move towards that vision. Well, what you will hear is that we are well ahead of schedule in terms of reach scale and impact. Our partners and the Agilon team that you're going to hear from today have made this possible and you'll hear from them about why this is so special and why we're so bullish on the future. There are three takeaways for you today. One, our market opportunity is inflecting. That's a function of two things. There is a need out there among virtually every physician organization in the country for a new primary care model that puts that PCP as the care quarterback. And second, we have had incredible success with the 11 markets that were live through 2021 in terms of demonstrating the impact that can happen locally. Second, we have a distinctive partnership and platform model that puts that PCP in an aligned position and they are able to drive meaningful impacts and we'll show that to you throughout the day. And finally, there is a massive opportunity for value creation as we change healthcare locally and nationally. Our vision is about empowering that primary care physician to play that role. We have made incredible progress in the last 12 months and we now have 2,200 primary care physicians on the platform. That progress for the first time gives us confidence that all of the primary care physicians in the country will need a new primary care model and that our total addressable market includes all types of physician organizations. And so in addition to targeting 100 plus communities that we're looking to transform for the first time we are adding to our vision this goal of 10,000 primary care physicians on the platform. The acceleration in demand that we are seeing has driven national scale for us. When you look at these numbers, 500,000 senior patients in risk relationships, 12 new states and 2,200 primary care physicians, these are critical national milestones that give us confidence in moving towards that vision. The significance of the class of 2023 that you'll hear Virile talk about beyond demonstrating broad demand because it is our largest class, is in the diversity of groups in that class. This class has primary care only groups, multi-specialty groups, scaled physician network groups. And this morning, with the announcement of Mayne Health, we have our first integrated health system with a medical group.

To say the announcement of Mayne Health is a big deal for Agilent would be an understatement. Mayne Health is the largest single aggregated physician partner in our history. They are the first state-wide partner that we've brought on the platform, and they're obviously our first health system partner. When you listen to Andy Mueller, who is the CEO of Mayne Health and really an outstanding physician leader, he's a family physician. He sounds remarkably like the physicians that you heard in the opening video. Primary care physicians across the country, regardless our group have the same need. And we know, given our dialogue with MaineHealth and the success that we're seeing in the early part of our implementation that we believe this is going to be an outstanding partnership and that every health system in the country will be facing a similar dilemma with the need for a different primary care model in a different way to take care of their senior patients. And healthcare challenges are requiring a scaled solution. We've said that since the beginning and it's more – it's never been more true than today. The senior population is growing 10,000 people a day are turning to age 65, primary care capacity is strained and physicians are facing burnout and there's incredible variation in terms of the health outcomes around minorities and low income populations. All stakeholders see primary care as the key to solving that dilemma. But physicians don't have the business model to enable it and Agilon has filled that need. Our success across diverse partners and geographies is both visible and compelling to physician organizations that are thinking about making the move to value. We now for the first time have basically a reference point for every physician organization in the country regardless of size and made may penetration type, the type of group they're in or the EMR that they sit on they can hear from doctors that look like them, that think like them and have made the same decision that they can give them confidence that they can make that move to value. Our success is not an accident we have

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made very clear strategic choices and we have refined those choices and there is a purity and a clarity to our business model. Those choices are one we have chosen to partner with existing scaled physician organizations, groups that have been in their communities for decades and are extremely well respected. Two, we are targeting fee for service, dominant geographies in which value is a relatively new concept. And three, and you'll hear Girish, who's our CTO and Dr. Dana Carne who is our national medical director, talk about this. We have been very purposeful in building a platform that enables those primary care physicians to play that care quarterback role. There are three advantages that come from those strategic choices. First, we are a first mover in these markets that allows us to shape value based care in these communities for decades, and it provides a path for other primary care physicians to join value through our partnership and our platform.

Second, local market scale provides leverage, and that primary care physician can now better influence activity outside of the primary care office, where the majority of costs occur. And then third, and this is such an important part of our secret sauce, we create that alignment with that primary care physician that comes from the right economic model that comes from the right set of data insights that they can leverage and resources that allow them to operate at the top of their license and practice medicine the way they were trained. An aligned primary care physicians and value drive, better outcomes. The holy grail in health care is to drive new behaviors that change how healthcare is delivering, and deliver better outcomes. And aligned primary care quarterback with the benefits I talked about of scale, of differential information and with targeted resources can make changes in seemingly small things locally that can have a dramatic effect from an experience outcomes and cost perspective. Things are changing with which specialist a referral is made to, which drug is prescribed, how many times a high risk patient goes to the hospital or the emergency room. The results on this page speak for themselves. Our partners are reducing healthcare costs and meaningfully influencing how care delivery is delivered. And our goal is to continue to improve that, align with – alignment for them and put them in a position to really drive outcomes. Our primary care physicians have the most important thing that you need in healthcare, a trusted relationship with their senior patients. That trust allows them to impact things differentially outside of their office. We will share many data points with you today. This, to me, is one of the most impactful, 89% of our patients, or nine in 10, rely on their primary care physician for specialist recommendations. That is a dramatic statistic. It's 2 times 3 times what I've seen in other open access models, and it reflects that trust that has been built over decades of our physicians being there and a decade long plus relationship between the patient and the physician.

And local market scale is crucial. When we have an online aligned physician and we're able to add local market scale, they can drive significant impact. While we are very proud of the 2,200 physicians that we have on the platform nationally healthcare is delivered locally. And when you look at these scale numbers in terms of primary care physician capacity and the total patients across Medicare and commercial, our partners are able to meaningfully drive outcomes. You can staff the market differently and you can influence specialist and hospital behavior.

Note on this page, we have our veteran markets of Columbus and Austin and Akron that have delivered strong results and have great alignment and scale, but a big part of our model is bringing on new partners that start with meaningful scale. And so Syracuse in New York and Pinehurst in North Carolina, they just came on the platform in January 1, start with meaningful scale and should be able to very quickly influence how care is delivered in those communities. In an aligned and scaled primary care physician, properly supported with the right information can meaningfully change local care delivery. Here we show you a year four market of Akron. You heard from a couple of the physicians on that video about how dramatically different things are for them. We show the old world on the left and the new world on the right what's difference. In Akron, we now have primary care physicians able to refer to top quality specialists. They have the information they need and they have a referral support team to make sure that that patient gets to that specialist. They also have the technology and the information to come back so they know when that appointment occurred, what the result was so they can discuss in the next primary

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care visit. We have resources in the emergency department that can divert folks to home appropriate and provide appropriate support and in the post-acute facilities we have staff that transitions people to the right side of care. The largest payer in the country's goals, CMS is a huge tailwind for Agilon Health. Recently they've announced the Reach program that focuses on equity and access and community health and they've said primary care is at the core of Agilon.

They've also -- as of this, last fall announced a 10 year strategy that says every Medicare beneficiary should be in a trusted relationship with a primary care physician in a total care model. These announcements are a huge tailwind for Agilon and the choices that we make strategically show up in our business model results that we discuss with you each quarter. We're able to grow more efficiently. We're able to grow faster. We're able to reach profitability within our markets by year two. We're able to drive meaningful, medical margin improvement and we're able to generate attractive subscriber economics that lay across a long term patient physician relationship.

All of these choices and the experiences that we're seeing say there is a massive opportunity for value creation for our partners and for Agilon. For the first time as I said, we are changing our aspiration to look at all of the primary care physicians in the country across all types of organizations with 2,200 PCPs in the platform, we've added that 10,000 PCP goal to our vision and we also now have real clarity, greater clarity on the value drivers for Agilon. It's very simple One, we need to increase the number of primary care physicians on the platform that comes through new markets and new partners, as well as growth within existing markets. Two, we need to increase the number of patients and do that by increasing panel size as well as organic growth. And three, we need to increase the annual value of a Medicare patient through the impact that I talked about.

And so let me tee up today, we have some really important themes that you're going to hear about from the team. The first from Veeral, you're going to hear about how our market opportunity is inflecting and our network is growing. Ben Shaker and our physician panel are going to talk to you about the compelling advantages that our partnership and platform bring to -- bring to them, and what that means for PCPs, groups and communities. Girish and Dr. Dana Carne will talk to you about the platform that we have purposely built that is enabling, enabling higher value care at scale. Tim, will talk to you about cohort data that shows our increasing confidence in member and primary care economics. And finally, Tim will show you a view out to 2026 that says the opportunity for value creation is massive. So this is going to be a special day. I'm really pleased that we have the opportunity to hear from our physician partners and our team and together collaboratively, these people and their teams are making it happen every day.

So with that, let me introduce Veeral. Veeral is our Chief Strategy and Development Officer. He and his team have had an incredible last 12 months. I'll give you a chance to hear from him.

Unverified Participant

Thanks, Steve. I've been fortunate to be part of the Agilon Health team since our founding. I'm thrilled to be here today. As part of my experience here, I've led the standup of our operating platform. I've let our market operations in the West and the East. Each of those experiences have given me a unique lens into the development of our platform and each of our physician partners.

Today, I lead strategy, development and the payer segment of the business, and I'd like to share a perspective around both the development and onboarding of our new partners across the country. So Steve talked about the market, and our opportunity is at a tipping point that's both a function of increasing well-understood macro factors, but really the impact that our success with current partners is having on the engagement with future prospective

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partners, as a result of the pace of our new market entry and our expansion into new partner archetypes inclusive of today's announcement around our first health system partnership. We have significantly expanded our total addressable market.

We have a very simple growth algorithm. We put partners on the platform. Those partners bring with them existing primary care physicians with embedded Medicare panels. We are creating the market for risk in each of our geographies that allows us to then add additional primary care physicians and members to address what is a massive in market TAM in each of our geographies. That algorithm, it's translated in 2022 into six new partners and 50,000 members and as Steve talked about 2023 a real inflection seven partners, 80,000 members. Our new markets have dramatically increased our TAM by 60% in a single year and it's our execution against that opportunity that's driven 15% same geography growth. The market is at a tipping point. It's our focus on existing physician capacity that creates a highly skilled Medicare opportunity. Senior population growth 62 million people going to 72 million people with rapid growth in MA penetration. The market we are now chasing is 200,000 primary care physicians across the country and a key driver of that opportunity is a PCP business model that is fundamentally flawed and fundamentally challenged, a declining fee for service commercial business, a nascent Medicare panel that is effectively a loser within their panel and their economics and a limited ability to meet the clinical needs of their vulnerable senior populations. PCPs are able to take on these challenges and fundamentally transform their business model through a partnership with Agilon Health. This growing demand for real PCP business model change, combined with the extensive success of our partners across the platform which you'll hear more about today is combining to drive a meaningful inflection in our business.

Two years ago, we were in 11 communities. Today we are live or implementing in 25 communities. 2,200 PCPs on the platform compared to 1,350 a year ago. That is what's led us to increase our guidance from 40,000 new members to 80,000 new members from new markets and we now have visibility in 2023 to 0.5 million numbers on the platform. The class of 2023, we're incredibly proud of our progress and the quality of the partners that we're bringing onto the platform. Four new states, 12 in total that's 50% growth in the number of states or hubs that we are now in. Eight new geographies, each of these new markets highlight our role in introducing global risk into those communities and are each of those geographies are early in their M&A cycle as Steve talked about, these are non-traditional risk markets and we still have tremendous benefit to accrue from the rapid growth in the Medicare population in each of those geographies.

This class of new partners also meaningfully expands our total addressable market inclusive of scale networks, multiple groups across different EMRs and now health systems which we're going to talk more about in the course of this conversation. It also highlights the diversity of the types of groups that we're working with. We have a health system group, a health system employed medical group with 215 primary care physicians. We have a primary care only group of 25 physicians. So why are we winning? As I'm out there talking to provider organizations every day I would tell you thinking back over the history of the company our conversation is fundamentally different than even two years or three years ago. The macro backdrop is a burning platform. Every primary care physician in the country needs to figure out what to do. The fee for service model is not sustainable. They need to get into value, and what we have is tremendous and unique product market fit. And now we have the proof points. Our physicians are winning across the board. And the power of the network is real. As you'll hear today from our partners there is nothing more powerful than a conversation with a prospective partner and hearing from one of our existing physicians in our network.

their experience before the partnership. Declining commercial business, Medicare is a losing business, dabbling in value, struggling to sustain their independence, post partnership, most importantly, they're able to invest differentially against clinical capacity against the patients that really need it, deliver better care, win economically, create long-term sustainability and fundamentally they are more fulfilled. As one of our favorite partners, Gary

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Pinta often says, I get to be the doctor I trained to be. This manifests itself in the type of physician organization, the number of engaged groups and the pace of our development cycle. So we just talked about we grew from 1,300 to 22,000 physicians in two years, 240,000 members to 0.5 million members in that same time period. Pace is the defining element of our model.

Our model has worked across diverse geographies, diverse market entry points allows us to enter a market at true scale, move the market to a risk. And use that for smaller advantage to unlock the tremendous in market opportunity that exists at a physician and member level. Pace is accelerating, now, it has this in 12 states, 8 states in our first five years for in 2023. Pace also reflects how we enter and stand up a new market. We immediately flip a market to risk. We sign a partnership. We go through an extensive 6 months to 12 months implementation cycle and we enter into full risk on a multi-payer basis. And as Be Shaker will talk about, our platform is getting smarter. We're getting to economic endpoints and most importantly We're getting to economic endpoints and most importantly, delivery system impact faster. That is a function of a hub-and-spoke model. We enter a state – we started in Columbus in 2018, four years later, we have five markets with five terrific partners. Austin, Texas, we started in 2019, we now have three communities in the state of Texas. It speaks to the power of the network – network effect within a state, and it also speaks to our ability to leverage common payer contracts, a common set of infrastructure we build out at the level of the hub and drive performance out of the box and to be very clear, in each of these geographies. We are early in the lifecycle of our opportunity.

Ohio and Michigan really bring these to life. Ohio, four years, four years ago, we got started with Columbus. Now we're five groups 400 physicians, 135,000 MA and DC lives. And that's against the backdrop of a total market that's 1.6 million of addressable opportunity that we still have in front of us. Michigan, we went live 1, 1, 2021 – or 1, 1, 2022. The value of a hub is increasing, as evidenced in Michigan. We've created payer contracts, a common set of infrastructure, and what we have now is an opportunity in front of us. That's 55,000 lives by 2023. And so when we started the company, the nature of physician risk and where it could be applied was very narrow. It was a Southern California and Southern Florida thing. We unlocked risk in a non-traditional geography in Columbus in 2018. And now we've demonstrated the ability to apply the platform across highly diverse markets partners, that's fueled a flywheel. For a new partner prospect, they can see that market looks like my market that group looks like my group, that physician she looks like me. Other players who want to move at that pace, they have to go buy a group and put that group on the platform for us because of the way our platform can be applied across these groups and archetypes without owning the group we can drive a pace and a differentiated competitive moat. Our partners reflect that our partners are 30 to 90 years in the community, trusted leaders these scaled assets in their geographies. I'm always so proud of the quality of the groups and you'll see that today in our physician panel represented by our physicians, primary care groups, multi-specialty groups, scaled physician networks they vary in size from 30 docs to 300 docs. And as Girish will talk about our technology platform allows us to meet them where they are to work seamlessly across the MRs and payer data to create a single physician experience at the point of care. We are adding hubs and that significantly addresses are end market TAM. This is a big question we get in a lot of our earnings calls. The power of the geographies we have entered is significant. Our end market opportunity you think back in 2021 was 4 million lives on that 4 million lives we were delivering 15% same market growth. Now we've grown that total addressable market to 7.5 million lives and that is with the addition of very attractive markets like the State of Maine that dramatically increases our opportunity, but also our confidence level around the total member opportunity and our ability to deliver sustained same geography growth. We are in some of the most meaningful MA and risk geographies in the country Ohio, North Carolina, Western New York, leveraging our first mover advantage in competitive differentiation, physicians and groups in our existing geographies are flocking to the partnership. We are the place in the market to access global risk to deliver a differentiated experience, to have a sustainable model and primary care. So because we get a lot of questions around in market town, this Akron example really brings it all to life. We introduce risk in 2019. We entered the market with the leader in the geography. We added a second community based group. We

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then scaled primary care capacity from 41 physicians to 73 physicians through a combination of acquisitions and hiring. We added a line of business. Now we're working across all of the seniors within our partner practices through the Direct Contracting or ACO REACH program, and we've tripled our membership in four years. This is the power of the model and the power of scale at work.

Expanding access points, so I finally want to talk about, we are expanding the way in which we enter geographies are access points into new markets with different partner archetypes. When we started the company, we had single physician groups, all primary care, physician owned and operated. This is a subset of the independent community opportunity. Over the last four years, we've added multi-specialty primary care and specialist groups, scaled networks providers on different EMRs and today we're announcing and very excited to announce our first integrated health system, a dramatic expansion of our TAM and importantly, a dramatic expansion of the application of our platform to serve primary care. So a lot of people ask about health systems, health systems are a natural evolution. We believe our health system partners are facing a common set of challenges to our existing partners. They lack an economic model for growing and sustaining primary care. Primary care is often a loser within a health system. Their Medicare business is a losing business, and now they're seeing more of their commercial business shift into Medicare, and they have no strategy to fundamentally pivot into value. To be clear, this is not any willing partner, but the right system partners possess the same ingredients, community focus, scale, leadership and governance, strong physician organization. Progressive systems like Maine, this is actually a great synergy because of their investments that they've made in ambulatory assets in primary care and specialty care that accelerates the move into risk, and fundamentally this represents a powerful strategy to unlock their Medicare business and transform the delivery system through value through the senior business.

So with that, I'm thrilled to introduce a video of Andy Mueller's, team talked about him a little bit earlier. A truly bold physician leader, the CEO of MaineHealth, he talks about a mission to build the healthiest community in the country. A need to invest differentially in primary care to achieve that strategy that is highly aligned with who we are, our mission, our belief set, but it's also reflective of our national opportunity. Andy has built a tremendous team, including a distinctive physician organization that will be our partner in this venture together. MaineHealth Medical Group is distinctive. It is the largest primary care group in northern New England, 215 primary care physicians. And so with that, let's hear directly from Andy on why MaineHealth has chosen to partner with Agilon Health. Thank you very much.

Unverified Participant

MaineHealth is the largest integrated healthcare delivery system in northern New England, where 12 hospitals, 22,000dedicated care team members and roughly 1,700 physicians 22,000 dedicated care team members and roughly 1,700 physicians in APP scattered across the states of Maine and New Hampshire. We are passionately committed to achieving our vision of working together so our communities are the healthiest in America. Agilon, we believe, is a step in the right direction and beginning to transform our business model and transform the way we deliver primary care. It provides us an opportunity to partner with someone who is experienced in helping physicians really better manage Medicare Advantage patients and at the same time, affording us a new revenue stream. There are number of things that attracted us to the Agilon team. We really appreciate their partners' style. The fact that they've got great experience in helping positions change behavior to improve outcomes for patients, and we really appreciate the perspective that they have in recognizing that every situation is a little bit different and affording some flexibility for us to make sure that we get it right for MaineHealth.

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Partnership with Maine, it unlocks a new segment of our total addressable market, and we believe our platform is truly at an inflection point and that is really driven by the performance of our existing partners. So, we're going to ask, have Ben Shaker come up and talk to us about how we're driving these outcomes with our partners. Ben?

Ben Shaker

Chief Markets Officer, Agilon Health, Inc.

Thanks, Veeral.

Unverified Participant

Thanks.

Ben Shaker

Chief Markets Officer, Agilon Health, Inc.

Good morning. So, I'm the Chief Markets Officer at Agilon Health. I've been with the company since the founding, so I started back in 2017, was hired to stand up our first partnership in Columbus, Ohio, with Central Ohio Primary Care. The best part of my job is I get to work each and every day with our physician partners I get to work each and every day with our physician partners, all over the network, as well as our Agilon Health teams in our markets.

We've really been able to drive a ton of progress in such a short amount of time. Going back to where we started in Columbus and to be operating across 17 communities today, it's awesome. The cool thing is I think everybody involved realizes just how much opportunity there still is to really redefine the delivery system kind of through the primary care lens. So today with that as a backdrop, I want to really bring alive three main points. First, I'm going to talk to you guys about how purposeful we've been within our model to really design it through the lens of the primary care physician. Second, our model is consistently deployed. We've built a platform that can be a very common platform that is consistent across all of our geographies. And third, the values proving out, I'm going to walk you through that.

We have a very simple goal. We are trying to drive healthcare change through the primary care physician. Our business model is predicated on our proximity to the physician. We're ultimately moving from the left side of the page, a very traditional fee for service model to the right side of the page, which is really built on a subscription based relationship. The nature of our subscription based model is all around the alignment and the mindset of the physician and patient that sticky relationship that takes place over a long period of time. Physicians are moving from a transactional model to a model to where they're now paid for quality and total cost of care outcome. We're also changing the dynamic from the historical model of physicians who only manage patients within the four walls of their office to a model that is really built around comprehensive care teams across the delivery system. And we're also creating a single experience, one that's not defined by the payer. That's ultimately what's different.

In order to make that work, we have two core concepts. Our model optimizes for the physician group structure. We felt that there was real advantages, as you heard in working through existing physician capacity. Within that structure, there's existing physician leadership. Physicians already have panels that are applied into the model, there's existing infrastructure across these markets, and the scale, the reputation and brand that these physicians group bring into the partnership is significant.

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On our platform side, we are very specific about how we've built out our model. We are focused on the senior population and so everything we've done is really built around how to drive support to get to the level of outcomes that we're all after. It's also purposely delivered our platform through the physicians in our markets, tech, people, process capital, everything is delivered through that partnership and our model is built on a shared economic foundation. Everything we've done to date is through the lens of how that leads to outcome. As you heard from Vural, we work with now physician groups of all different sizes, types. It's a very diverse group. But in order to operate effectively, we've delivered our platform in a very common way.

As I talked about we moved from the physicians that were in a fee for service model moving to risk. They weren't equipped to do that. The payment model didn't support it. The care didn't transcend across the delivery system. The data that they've had access to is really through what's defined in the EMR. As each one of our partner who joins our platform, it's getting smarter and it's getting stronger. We're moving to a different model and we're doing so in a very purposeful way. We've been very intentional about how we operate across our markets.

We've designed our operating structure to work just like any other multi-site business. The structure that you see up here is very similar and is very consistent across all of our markets. We operate through our physician partners. We operate using a [indiscernible] structure that includes a physician leader and each one of our markets from one of our groups. Each one of our partnerships is governed 50:50 and we operate with a shared resource structure between Agilon Health Resources and the existing resources and team members that are already part of the partner organizations and this creates significant leverage for us. It allows us to port our model rapidly and effectively and to do so on a very consistent way.

Given the components of our model and how we've structured ourselves and how we work with our physician partners we can get after very -- we can get after operating metrics in a very differentiated way. The types of metrics that we're focused on really allow us to drive enhance quality and cost savings across the board. When most people in value think about what metrics are tracked admits per thousand when most people on value think about what methods attract, admits for thousand. That's something that we look at as well. But we've been able to move beyond that. For instance, given our local scale across many of our markets, we're working with hospital partners to impact observation stays, but that might be unnecessary from patients coming through the ER. We also make investments in things like physical medicine and rehab to create alternatives for potentially unnecessary surgical interventions. And because we're in the senior business, we have the ability to manage our highest risk patients and provide services such as home-based palliative care to help manage unnecessary utilization. This is all possible because of the alignment that we've created, how we're deploying our platform and the local scale that already exists in our geographies. All of this ultimately drives a flywheel effect. Because physicians are aligned around outcome we have the opportunity to drive performance through the group structure. This is an example of one of our physician partners and how they've even evolved over the course of the three years that they've been in our partnership. They have redesigned their compensation model. They moved from a traditional fee for service model to one in which rewards them for quality and cost. They've taken the data that they've had, and we've been able to infuse additional information to actually create insights rather than just a fragmented set of information. And finally, the impact to this practice from the senior line of business is significant. And as we continue to drive outcome, it does create that flywheel effect. They get more excited about what we're doing. We're investing in more capability.

They get more excited about what we're doing, we're investing in more capability, we're growing mindshare from the physician base. The flywheel effect is powerful. We know there's variability everywhere in healthcare. We talk about it all the time. This isn't new. But our proximity to the physician allows us to get after it in a very differentiated way. We can impact the micro variability at the provider level. You can see in the scatterplot here what we're working to do is the move – is to move physicians to the lower right quadrant. This is an example of a

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group that has 41 physicians. We're operating at the physician level powered by their engagement, their alignment to the outcome, our ability to provide better data. On the right side here you can see just the significant opportunity that exists across our markets given our local scale. So when you look at what we can impact at a very granular level as it relates to physician level variability and then you take a step back and you can see given the local scale that we have in these geographies, we can also impact large buckets of medical expense. Our model allows us to scale fast. You heard from Veeral in terms of just the rapid growth that we've seen and what's on the horizon but because we operate in a consistent manner with such pace what we can do is we can grow in a way that not only drives the performance, but it looks very similar. And so when you look to see how we've grown and what that means you can see here we're operating in over 400 sites, 17 communities You can see here, we're operating in over 400 sites, 17 communities and places like Columbus we've gone from 20,000 members to 70,000 members. We've added geographies in Ohio from 1 to 5. In Austin, we've went from working with 2 partners to 7 partners. We've added an entire line of business last year around direct contracting. All of this is done, built around the same regional infrastructure, the same data structure, the same clinical programs, leveraging common payer contracts. We are designed to scale and operate at scale, and that leverage is significant. So what is really exciting here is when we started the business and what we wanted to see happen and what we were driving towards in terms of outcome and changing the delivery system for the primary care physicians and their patients, it's starting to prove out. We're seeing strong and improving quality cost and experience outcomes. Our gross medical margin is improving in our most mature markets and our cohorts are improving as well. Market medical margin across all classes of partners is also improving, kind of driving home the consistency point. And we are sharing more dollars back with our primary care physicians to reinvest in how they're transforming their own practice as well as the delivery system.

So the separation that we see between our performance and some of those national benchmarks is significant. And at the same time, we're also driving improvement. Take access. We're able to identify patients in a way that we can identify who needs to come in. As we're able to improve these access measures we're seeing correlation back to improved utilization measures. So not only are we seeing admits per thousand improving, we're also seeing ourselves perform better than many national benchmarks. And we're doing this all wrapped around a patient experience that is very, very strong.

Our medical margin is growing exponentially. Looking at our most mature markets, we know there is significant ability to expand across these geographies, both in terms of margin as well as growth, and you can see that compounding effect. You can see as we've grown our membership across these most mature geographies that we're expanding medical margin 4x. This is with growth of over 70%. And another look of this shows just how those older cohorts are performing, you can see here are 2018 and 2019 cohorts. Our 2018 cohort which started in a good place, has still seen significant year-over-year improvement. Our 2019 cohort, while starting lower has seen a much higher rate of change. This gives us a ton of confidence in the value of a member who comes on to our platform, and you're going to hear a lot more from Tim in terms of the details behind this. We're also seeing that individual market level performance, we are working at massive scale and here regardless of starting point we are seeing consistent improvement across these geographies. And these numbers are inclusive of some significant membership dilution. Again, the value of the members on our platform is proving out, and it's happening on a scale basis.

And finally, because we're in the partnership business with an aligned economic structure, one of the most important metrics that we also track is the value going back into the primary care model. This is another example of the flywheel effect, as we drive towards more of a value centric model, it creates a new level of economics, one that can be reinvested back into the business to align the primary care physicians to create more mindshare and to invest in the capabilities that are also – that are ultimately going to drive patient care. This is ultimately why we believe everybody should be contracted in the structure.

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So in closing, I want to reiterate four key takeaways. One, we are optimizing for the alignment with our partner. This is foundational to our business. We deploy a common platform across all of our geographies. Our data and insights are getting better, and you're going to hear much more about that. And finally, the network is getting smarter and stronger with each new group that we bring on to the platform. So that you're going to hear a video from Dr. Pinta and Dr. 00:54:30 de Janeiro to our great physicians in Akron, Ohio, with Pioneer Physicians Network. They're going to build on some of my points and also really reinforce the importance of that physician patient relationship and how it applies to the model.

Unverified Participant

Hi, Ray.

Unverified Participant

Hi.

Unverified Participant

How are you?

Unverified Participant

I'm doing well.

Unverified Participant

Nice to see us. Good to be seen.

[Video Presentation] (00:54:54 – 00:55:06) unable to deliver the quality care that they deserve. For years, independent physicians like me search for a solution that would allow us to care for patients while remaining autonomous, controlling our destiny through our partnership with Agilon Health. We have transition to a value based model of healthcare. This allows primary care physicians to be in the driver's seat, controlling quality, patient experience and efficiency. Now our physicians are rewarded for keeping patients healthy over the long-term.

Unverified Participant

Thanks to our collaboration with Agilon Health. We offer our patients a more effective team approach to healthcare delivery. We now have more nurses and medical personnel in our clinic and we deploy care coordinators to check on patients who are homebound or in long-term facilities and report back to physicians about their progress. Agilon Health has helped us keep our patients out of the emergency room where they are

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more susceptible to infection and incur higher medical expenses. The partnership also gives us access to real-time data to monitor patients healthcare progress outside the exam room. We can then troubleshoot catching chronic health conditions before it's too late.

Unverified Participant

And with extra help with data, I now have fewer appointments and spend 40% more time with my senior patients, ensuring a more preventive and comprehensive approach. Because of the collaboration with Agilon Health, we've been able to grow our practice and in 20 physicians and over 20,000 patients.

Unverified Participant

Our patients are now getting better care than ever. Our high risk patients have 44% more points of contact with healthcare team members and doctors are happier too.

Unverified Participant

The long-term relationship between a physician and patient is the most valuable partnership in the healthcare universe. It is the best way to drive behavior and thus value.

Unverified Participant

We have [Technical Difficulty] we've got about 15 minutes for Q&A and after that, we'll take a quick break, but with a couple logistical things, we've got some mic runners, so if you could just raise your hand, we'll get a mic over to you. If there are any questions from the virtual audience, please just email the Investor Relations website.

But why don't – why don't we go with Lisa Gill, I see she's got her hand raised. And if you could state the name of your firm and you're.

Q

Sure. It's Lisa Gill, JPMorgan. Thank you so much for all the detail this morning. Steve, let – let's start with the main announcement. Really just a couple of questions there.

A

Sure.

Q

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As we think about this, one, what does that add to 2023? You've already given some updates on our membership, so if you can talk about that? And then secondly, as we think about 2023, are we done with the class of 2023 or is there still opportunities to add more, sorry, more work on the barrel?

A

No. Thanks, Lisa. Well, as we said, we're really excited about the MaineHealth announcement. It's our first health system partner and I think it opens up the opportunity for potentially more down the line. Andy's a great first partner to – to work with and a visionary. You know, I sort of think about him the way Bill Wulf, who is here, we started with COPC in a primary care only group and Andy really, – really opens that up. And so, you know, the majority of that class came from our other – other partners that are there and Vural can talk about that. But it does add our largest physician group and it is – it is the largest member count, I think, within that – within that group. So it's meaningful for 2023, but it's also meaningful in terms of longer term. Vural?

Q

But, maybe before you want to, like how do I think about it in the longer term, and this is – opportunities where we're going to see you start to partner more with health systems so that we think about overall cost? Are we thinking about health systems because they are not really sure what to do with primary care doctors? I mean, how do we think about it more from a bigger picture? Yeah.

A

Yeah. Well, holistically, as Vural said, they look and sound and feel like a lot of our other partners.

they have the same issues around primary care capacity and burnout and they need the deal with this growing senior population. So I think, that there is a need there. Tim will show you kind of an outlook to 2026, and I think, what we'll say is there's different paths that we can get there on, we feel really good about sort of how we've been doing things, but this opens up an additional opportunity for us and we're going to learn a lot through this implementation. So I think what we said is our opportunity set is broad.

A

Yeah, I would just say on the core independent segment, that remains robust. It's a majority of the new membership that we're going to be putting on the platform as Steve talked about specifically as it relates to health system, I made the comment pretty deliberately to say it's not any willing partner and that's really the case for us nationally. I think what makes this particularly unique is we have won some of the – the same underlying means that we're solving for relative to our existing partners. They don't have a Medicare is a loser for them, they don't have a way to accelerate into value but some of the unique attributes relative to Maine is they're extremely strong physician led, we're partnering with the medical group organization, our ability to integrate from a technology and data standpoint on their epic platforms gives us high levels of confidence around the execution and reaching similar level economic end points in terms of what does mature medical margin in a market like this looks like, but I think what Steve talked about is important, this as archetype will be a tremendous learning experience for us to say how big and broad can the aperture be relative to this segment of the market.

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A

And I'll just add, we are talking to other health systems that look and sound like [indiscernible] 01:00:53 in the main health team. That doesn't mean necessarily we're going to be doing them in the near term. But as we learn a lot from this, That doesn't mean necessarily we're going to be doing them in the near term. But as we learn a lot from this, there's that opportunity.

Q

Okay, great. Thanks.

Q

Great. Thanks. Two questions, one is obviously healthcare. Healthcare is local, but as you think about moving across the country and being more broad nationally, what are the kind of non-obvious benefits of that understanding that there's reference accounts and all that, but like what does a bigger national footprint get you? And the second question is, as you think about standing up each one of these markets going to 23 markets now, lots of different communities can you talk a little bit about internal ads on hiring, like how many, how big the teams are, how that's evolved. What are the phenotypes of the kind of individuals you're looking for?

A

Sure. So I'll start on national scale, and maybe you guys can add in. I mean I think national scale is making us much more of a player. And the first point is there are groups out there that can see someone with an Agilon that look and feel like them. So there is that reference ability. But that national scale gives us tremendous benefit with payer's right? The integration that we're seeing with our largest payers, the joint operating committees, we have standard data formats with them. We are talking about expanding into other geographies. We have the ability to bring a national payer into a market literally within six to eight weeks, like we did in Buffalo with a couple of national payers. And so I think that that national scale makes us much more of a player from a payer perspective, we all have been.

A

Yeah. The only other thing I would add is, you talk about network in terms of reference ability around the development process. I think the biggest place the network effect plays is operationally. What type of type of comp model are you driving? How are you getting to that level of outcome around your palliative care program? And so I think that network effect is very real. But I think the biggest place it actually plays in helping us replicate, create labs in markets develop clinical programs, poured them across the country and create similar benefits and outcomes across communities.

A

Just one thing I'll add to that is last week we had our Future Medicine Summit. We had 120 payer representatives, including the Innovation Center attend that it's really because of our national scale and the different payers or

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partners that we're able to bring together. And so we are seen as a leader, we're seen as an innovator. I think there's an opportunity for us to influence growth more, but also policy.

A

Yeah. And this is Jason, I was going to take your hiring question. I mean, certainly the talent piece is critical, especially as we scale a couple of things first a lot of people that we have on our teams today have grown up in the business, because we're still so early in the life cycle and so those people that have helped build the model. And know it as well as anybody what we're doing is taking those geographies and starting to even supplant people that are operating in existing markets and kind of moving them into our newer geographies. We're hiring kind of earlier into our implementation process to where we're getting people in the seats much more, much earlier on. And we're also, I think have done a really good job finding talent in our local geographies. So bringing in team members who you know are really, really understand the group, the local dynamics and kind of then plugging into some of the subject matter expertise that we already have at a platform level.

A

Yeah. On the talent issue, I would say that's been a huge focus for me Jason, I mean, we've added incredible talent and we being exposed to some of them this morning as we go forward. Our hiring practices Andy Mueller said to me last week. What is it that you're doing at Agilon to bring in these people because they're not just exceptional in their field and bring functional expertise, but they're tremendous collaborators and we've built a really great team. And so we have ramped our hiring tremendously at all levels. I think for us to pursue this opportunity the way we've laid out we need to win on the talent side and we need to bring in exceptional partners like the ones you're going to hear.

A

The one place just on talent I double click is technology. If you think about the biggest place we've made progress in the last 12 months and Girish will talk about this in his talk is both the phenotype, the quality of the talent and the capability set. And that's been an area of significant investment in terms of where we put both capital to work, as well as deployed our stand-up of our India Development Center and again the quality of the talent against one of the most important aspects of the business which is the technology and data integration that drives the ability for a physician to really engage at the point of care differently.

Q

Kevin Fischbeck, BofA. I guess two questions, first one with this health system partnership, you've mentioned that there's a lot of similarities that you're addressing in this versus a normal PCP relationship. But obviously there's another one that the hospital group got that physician group in the first place to drive volume back to the hospital. Now you're helping them keep people out of the hospital. So how does the hospital think about the economics of this with the physician groups pretty clearly to improve it? Here there is losses on one side, gains on the other I can almost imagine economics not working out potentially if you're very successful. So how does that work out?

A

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Yeah so it's about partnering with the right progressive systems. Main health is not looking at Medicare to drive their inpatient strategy. Medicare is a losing segment of their business today. They have an unsustainable model for funding primary care and growing primary care. And so what this really allows us to do is take advantage of the unique assets of the healthcare system. Hospitalists to drive ED diversion, the ability to leverage the significant investments in ambulatory assets that in this strategy, a risk strategy, a value-based strategy you can monetize, you know post-acute the ability to interact with PCP owned facilities. So I think it goes back to not any willing partner. And how does a risk strategy and a senior strategy help asset, help really address and accelerate a primary care oriented strategy and turning Medicare from a losing business into a winning business and an ability to advance the community mission on that basis?

A

Yeah, Kevin the reason I said Andy and Maine are such a great first partner is there's alignment with what we're trying to do. They like the idea of fewer senior patients in the ER. They like the idea of fewer senior patients in the inpatient setting, and they're looking for primary care to be something that they can invest more in. They lose money on primary care today, they lose money on Medicare. This allows that to transition and really take primary care to the forefront for them. And it allows them because they're really at capacity to potentially add more commercial business into their, into their facilities. So it's really it lines up very well from that perspective.

Q

Okay, and that's, the last question, you know, you mentioned that all these partnerships are helping kind of feed on the next one to become kind of -- becomes this momentum that you create by adding more partnerships. At the same time, though, it seems like competition is increasing as well. I mean, I assume that your success rate is not a 100% to the extent that you work with Agilon Group and ultimately they choose a different solution or different outcome. Where are you losing to? Is there something else that you need to add or other service line need to be offered to be competitive to capture all the opportunity?

A

So, sorry [indiscernible] (01:08:38) from a new market perspective, Kevin, new partner, new market for the groups that we're talking to that are scale and have the characteristics that we laid out, we are not seeing as much competition there and frankly our success is driving that. The place we see competition is in these geographies. And so we tried to show you the size of the other groups that sit within those communities, groups that might have sold to a health system. Historically, that was a small independent or a group that might have sold out to Optim. We're now starting to see them join in, but that is definitely the area in which that competition in the capital is coming after that. The arrows point about pace, I think is an important one in that.

A

And I think it's about the quality of the group and their mindset. If a group wants to go sell, we're not the right partner, but it's a massive market of physician groups that want to stay independent and that there's a real commitment around the senior patient population, the ability to leverage a different model, a different payment model to do more for that patient population and sustain and advance their practice on that basis. So I think just like we talked about with health systems, I'd say the thing that we've gotten much more deliberate about is our

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filtering criteria around what's going to make an attractive partner and a partner that can win in our model. And I think that's really supported the success of our existing partners in our across the platform.

A

Yeah, I mean, I tried to hit this point about being this first mover into geographies that are not familiar with value, Kevin, and so we're basically creating the opportunity there. The groups that line up really well are those that are at scale and thinking about making that move not just for themselves, but for their entire community. And in fact, you know, just as an example, we'll announce our class of 23 partnerships here over the course of the next couple of months. The reason we're doing that this way is because we're introducing value in these communities. And it's not just about the group. It's about what the other physicians within the community are going to hear around that.

communities. And it's not just about the group it's about what the other physicians within the community are going to hear around that. And so that's the advantage of being this first mover in these geographies.

Unverified Participant

I'm going to cut it off here we're just to keep us on time there'll be plenty of opportunities for additional Q&A throughout the day. We're going to have a 10-minute break. So if you could please rejoin us at about 10:20 Eastern that would be great. So thank you.

[Break] (01:11:16-01:12:48).

[Break] [Break] (01:16:42 – 01:18:42) [Break] -01:20:39) [Break]

Unverified Participant

I'm going to introduce you to our Chief Technology Officer, Girish. Girish, thank you.

Unverified Participant

Thank you, Mike. Welcome back, indeed. I forgot that I need to do a clicker thing here. Yes. I was also on a break. So, over the next few minutes, I'll talk more about how this platform that Steve talked about this morning, how real is it, and how is that we rapidly moved partners to risk, how is that we enable higher value care and we will actually demonstrate how we operate at scale, and what gives us the confidence to handle the growth that Vural talked about. And how do we believe that we can actually deliver consistently.

I've spent two and a half decades building skilled scaled systems in data and AI. Prior to Agilon, I was at an EHR company that had over 100,000 physicians in their network. So I thought we were doing great. And it's only in joining Agilon, and really walking in the shoes of our physicians, that I appreciate, wow, all the data we were giving them was only so much of that story.

So let me take this example.

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There is an 82-year-old Mrs. Jones, who has COPD and walks into one of our physician's office with shortness of breath. The physician has to figure out, is the shortness of breath due to the fact that she didn't fill her refill or is it that something about some specialist she visited, changed some medication, or is it some hospitalization that changed something. Anyway, the physician has to look through myriad data sources.

The thing that our physicians describe is how, despite all this data, they're flying blind. And this is for one patient, for one episode. Imagine how bad this is if they have to take risk on that patient. In order to do that, they have to understand the claims history, the pharmacy claims, this, that and the other. Flying blind doesn't even begin to describe their challenge. Most of them will say they can't even get to take off. And they have tried. They understand the existential crisis that Veeral talked about this morning. They have tried. It's not for the lack of trying. As Dr. 01:26:06 [indiscernible] talked about in the video, it has been incredibly hard. They didn't have the talent to do it. They didn't have the capital to do it. They couldn't bring it all together. And you have to do this day in and day out every single day. So, this is really where we come in. This is where our uniqueness starts. This platform that we talk about, the thing that we do is we're able to take data from This platform that we talk about, the thing that we do is we're able to take data from all of these diverse sources. We stitch it together in what we call as a member information profile and construct the single longitudinal view of that patient across the entire landscape and we then extrapolate that to the entire panel that the physician has and help enable them to see this bird's eye view of value based care.

And just to give you a sense, we do that across billions of data points just over the last year we've enabled over a million touch points for our physicians with this information and we do this every single day for every one of our members, in every one of our markets for every one of our physicians and our physicians are delighted because we've made this information relevant in the context of care. They're delighted and if my clicker works, that's not just it. It gets better, not just do they love the information and how we assemble it together for them. They love, how we deliver it to them.

Firstly we are consistent across payers. Most people don't realize how varied the information is that they get from payers. The fact that we credit together and we are consistent and they know exactly the same place to look for chronic conditions, the same place to look for a medalist, same place to look for a problem list makes it so much easier for them.

The second thing they love is that we slipstream this into their existing workflows – into their EMRs if we need to. If they don't have to learn anything new, they don't have any training costs associated with it they start to see the information in context of all the things and exactly how they've been practicing medicine over the last you know X number of years. And this is amazing, right. And you can already see that with that information you know our physicians even in the video talked about how they're starting to see their higher – you know in a higher risk patients more. This enables them to get that view. And you know you see that they're actually doing 44% more, right. And they get to see and reassess chronic conditions much more easily 98% right now let me get to the third part that is exciting is that not just do we delivered this information we actually listen to feedback of our doctors. If our data is wrong or something is incorrect we work to get that corrected if we don't deliver it into the right workflow we make sure that it does get delivered better, right. And the fact that they don't have to learn your system. I know many of your investors it feeds into the fact that we have low capital cost, we don't have to buy them EMR or buy them some system or have them buy software it lowers capital costs. The thing that's really beautiful about this is that they trust the data. They trust the data and it gives them the sense of co-authorship and co-ownership. And it really helps them champion this bargain with champions. Let's hear from our national medical director and how all of this differentiated and rich data is actually making a difference in higher value care. Dr. Carne.

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Unverified Participant

Hi, Girish.

Unverified Participant

As Girish said, I'm the National Medical Director. I joined Agilon amid a career specifically focused on how to improve the value of care from Dartmouth to Massachusetts General to McKinsey to a value based care organization in Philadelphia and finally to Agilon. And speaking with all these physicians as well as my own practicing history, it's clear that physicians aren't waking up wanting to practice low value care. They just don't know how to. They don't have the right information at the right time to be able to make the right decisions. And this is why what Girish has built is so innovative, its purpose built to deliver higher value care. For example, I – when a physician is looking at data that payers giving them it's one piece of the puzzle and they have to sort of extrapolate what the rest of the puzzle looks like. When you can combine all the data together, I don't have to convince a practice or a physician what their ED utilization is in aggregate by just one piece of the puzzle. We can combine all that information together to show them their ED utilization and then go a step further to actually show insights on what they can do to improve that utilization. For example, this practice had high EDI utilization and we realized that Mondays were especially high utilization for them. We worked with the practice and found out that they were short staffed on Mondays and due to the excessive high call volume on Monday mornings and people being on hold and going to the ED instead and fixing that shortage was able to significantly reduce their ED utilization.

It also allows me as a medical director to understand the variation and the value lovers across all our networks and allows us to learn from that variation and be able to attack it. Be able to address a specific area where a market can improve in value to be able to learn in a specific area where market is doing well in value and understand where to invest in clinical programs to be able to address issues that across the network. And all this data and insights and information creates a educational and activational mechanism for PCPs to start to understand how to learn how to drive value and practice high value care.

Our scale and data infrastructure allows us to leverage insights from across the network to identify and deliver high value opportunities at all levels of the business. So, for example, we can look at any one market Austin, for example and see that their PCP touch points is a quite a bit less than the agile on average and that their cardiology patients being referred to cardiology is quite a bit higher than the Agilon average. And these are two sort of specific insights that we've been able to understand over the past three years, given the immense data that we've had access to and how we've been able to structure it and then act on it as well. Austin was able to hire three new cardiologists specifically because of this data focused on delivering high value care, not interventional cardiologist. And we can look at a segment in a market such as we call a pod to understand specifically what is that, what is practice care look like in that segment of the city for example this pod one in Austin, they had an especially high readmission rate and we're able to correlate that with not many people were being seen within two days of discharge. And this is another sort of specific insight that we were able to see at Agilon that there's something special and unique about seeing patients within two days. Seeing patients within two days doesn't work in a fee for service world. There is a 14 day or 30 day, but in a value based care world where you can reduce the readmissions, there's all of a sudden a way to do that. We can look at any physician and understand their opportunities to improve value of care. There is a physician that our medical director in Columbus was working with and in Ohio, who had especially high utilization of vitamin D tests. And we know that this test for most people is hardly ever necessary. The guidance now is if there's a concern about vitamin D being low to just

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supplement, and that's safe and effective and high value. And so she is able to work with this physician and reduce unnecessary, low value testing. And there's a host of other examples. And then, of course, at the patient level, being able to show for any one patient, you know, for example, this Miss Jones do for a colorectal cancer screening, she's seeing seven different specialists and four of them are ones that we've identified as low value. And so the physician can have a specific conversation with her about how do we -- how do we collaborate and do this better and see that she is at three avoidable admissions and talk with her about understanding the risk factors and what we can do to reduce these avoidable admissions. We can do this across the entire network for any market, any pod, any physician, any patient. We understand that to succeed in this business, we have to get our physicians to do something different tomorrow than they were doing yesterday, and this data and insights and specifically activating our physicians is allowing us to do that. So we turn it over back to the Girish to understand -- to talk about how we do this at scale and what's ahead in the future.

Girish Venkatachaliah

Chief Technology Officer, Agilon Health, Inc.

Thank you, Dr. Carne.

Unverified Participant

Thank you, Dr. Carne. And it's always such a pleasure to be working with physicians like Dr. Carne. So one of the things we talked about that Veeral highlighted was pace. We fixate on speed. So the nice thing is that every time we see an EMR in market, we build a reusable pattern on how to work with that EMR. We see a new Payor contract in market. We build a reusable pattern with it. Our goal is that every time, the next time we see it, we are that much faster.

Let's take the example of MaineHealth that we announced this morning, right. When we started the conversation, they were like, Oh my God, we had a massive epic shove. How will you do this? I said, okay, this is how we have done this in Buffalo Medical Group. This is how we've done this in Austin regional clinic. This is what we have learned from that implementation. And it was this straightforward conversation on how do we start to do this with them. But it got better, right. They were like, oh, this is how we send data to our population health provider. We're like, okay, how can we leverage that, and so we start to collaborate on it, and they want to think about like, how will we handle 200 physicians. So we are talking about how we do a single sign on across our both networks. These are examples, but the point is we don't worry about the 40,000 members that join our platform. What we fixate on is how do we do that at speed? And we not just with MaineHealth, we do that Payors too. Heidi, we'll talk more later on today about Payors.

We're doing that same approach to Payors, like how do we get data, how do we get data sharing with you in a way that is agile and nimble. But even more impressive than all that is, how do we take all this information and how do we assemble it at the backend? So what we have built is this consistent information backbone we call as the So what we have built is this consistent information backbone we call as the Agilon Information Model. And this is really what gives us at least three advantages. One to all the things that Ben Shaker alluded to this morning, this is what lets him and his market operators see all of these markets in the same consistent way, the same consistent way, right. So whatever be the endpoints in how we get the data when it gets mapped back into our enterprise, we have the same consistent way of looking across these markets. The second is that it lets us drive programs and operations very consistently, right. So when we construct the program, we're able to deploy it in these markets with the same speed and ease and measure their effectiveness as if, across all of this. The third, probably the most beautiful thing of it all is that we are able to spot best practices what works in one market, take it and see like, hey, this set of interventions with this set of conditions is what is probably the best practice that

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you should learn from, and the physicians start talking to each other then they just start to get themselves better at this and that flywheel effect that everybody talks about. This is really how it really manifests.

Not just that we're not resting. We're investing to stay ahead. We're investing to stay ahead of this game. Perhaps the proudest thing as a technologist is that we will be 100% cloud based by third quarter of this year. We will be retiring all of the Agilon data centers and 100% on the public cloud, uses incredible agility and flexibility, right. We don't have to worry about supply chain problems are doing you know four months ahead because MaineHealth is coming on board or any of that. We can spin up compute in seconds now. Equally, we can spin down computing second still, so that it saves lives on cost. The second, wait I'll allude to this on the talent discussion that Jason was asking about, is that we have set up an office in Agilon India. We had already 50 employees. It gives us access to an immense talent pool. And not just that, it gets us the ability to stretch our day to the full 24x7. And we have to follow the same model that makes it so much more effective for us to deliver that much more capability. The thing that we're also doing is we are focusing on building parts for the manual, mundane, repetitive tasks that either our market operators do or our physicians do. And this is really allowing us to have them practice at the top of their license. Perhaps the thing that I'm proudest of is the investment we are making in AI. We're starting to see that were real fruits already. But where we are state that we are heading to go is even more exciting, right. Take this example of Mrs. Jones where I started this conversation, right. COPD, but we also know that she lives in Buffalo, New York. We also know that is June. We also know that Buffalo, New York is the top 10 places for seasonal allergies. We also know that she hasn't refilled her medication. The question really is what do we do with that information? More importantly, when does that care team need that information? And what is the right intervention?

because Mrs. Jones doesn't answer to text messages only to a landline. The point is simple, I don't know what we will do with it. But what we're trying to do is go beyond the healthcare system and data just in the healthcare system to the wider world of data out there and bring it all together in the context of care. And this could mean the difference between Mrs. Jones spending time in her garden or in the hospital bed. And you need AI to triangulate that large troves of data and to do it at speed. And to do it at speed to be meaningful at the point of care that is what we're investing in. The thing that is true is that no matter where we go in the future, the one thing that is sure about our lives is that our goal is to delight our physicians and we don't ever get confused by the fact in their success lies our success. Thank you.

Q

Great. Thanks, Girish. Thanks, Dana. I think that's a tremendous example of a competitive advantage that Agilon has. What these two guys have created with an incredible team that allows us to take a market to risk for the first time. Hold together all of that information and provide the primary care physician and the group with that composite view across a panel is really unique and it's a big part of our success. And so now I get the chance to introduce our physician panel. I think this is going to be a big highlight of today for you to hear really how this works in a series of diverse markets. And so Ben Kornitzer, who is Chief Medical Officer, will come on up here with Frank, Pat and Kevin. So guys, come on.

up.

Benjamin Kornitzer

Chief Medical & Quality Officer, Agilon Health, Inc.

Thank you, Steve. Thank you, everyone. I'm Ben Kornitzer, I'm Chief Medical Officer. I'm also a primary care physician. My own area of specialization is the care of high risk homebound older adults. I've been with Agilon

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since 2019. Before joining Agilon, I was the Chief Medical Officer for Mount Sinai's Network here in New York. And prior to that I led the largest community-based ACO in New York City. My entire professional career has really been devoted to high value care for seniors, and my core belief is that there's no more powerful intervention when it comes to impacting your healthcare system than the deep relationship between a physician and their patient. These are remarkable partners. Each one of them represents the leading group in their market. They have tremendous influence. They have tremendous credibility. They've been taking care of their patients for decades.

One of the things that I would point out is they represent a whole range of different practice archetypes. We have groups that are large multispecialty practices in urban centers. We have suburban primary care-only practices. And then we also have distributed primary care IPAs in rural geographies. What we'd like to do is sort of see what it's like to touch and feel our practice through the eyes of our physician partners and really understand why they've joined Agilon and how that's transformed their model.

QUESTION AND ANSWER SECTION

Q

So, let me begin with my first question for Dr. Spencer. So, tell us a little bit about your practice. Why do you join Agilon, what was it about your business model that you felt you needed to change?

A

Sure. Thank you, Ben. Thanks for having us. So we're one of the markets where we had two different practices come together So we're one of the markets where we had two different practices come together and partner with Agilon as an anchor group in Austin, Texas, we now have seven different practices in that geography as you heard a little bit about our growth. And really what we saw is fundamentally our business model was unsustainable and despite our success these practices had been in the geography since the 1980s for decades as we said you know we had about 700,000 patients and you know we started with about 15,000 MA patients is now over 30,000. Yet yet in the model we saw our practices getting less and less valuable year-over-year as more and more people aged in the Medicare model, so we knew we needed to do something different. We knew there was inherent value and in value-based care especially in the senior section, but we did not have the capability to get at that without a partnership. So we were looking for a partner for someone who could help us, and that's when we were introduced to Agilon. We learned so much from Bill Wolff in Columbus. We were the second market with Agilon so that network of being able to go to other peers to say, how does this work was something that we were able to take advantage of. But those though we were really solving for that. We saw fee for service medicine, you know, declining our economics. We saw labor costs increasing. We saw you know overhead increasing and we know – we knew that we needed to get into something where we could tap the value of those senior lives within our practice.

Q

Okay. Thank you very much, Dr. Spencer. Dr. Salvatore, so it's the same question for you can tell us a little bit about your practice, why you joined Agilon and you know what sort of the impetus was for changing your business model in Pittsburgh?

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A

Sure. Hi, I'm frank cemeteries I'm a boarded family physician and geriatrician. I practice with my 42 partners in Western Pennsylvania, primarily around the Pittsburgh area. We're an independent primary care only physician group. We've been in existence since 1994.

We were pretty successful as an organization. I think as primary care physicians, we became increasingly aware of the fact that we were unable to touch our patients in the outpatient setting. We felt handicapped and felt an inability to actually reach beyond our office visit to impact the care that we deliver to our patients. As a result, when we looked at if you think about it, a Medicare patient at best may be in your office four times a year for 30 minutes, that's a total of 2 hours of face to face contact with the patient. Obviously, what happens outside of the four walls of our practice is critical to the patient's health care. We tried to make some inroads into developing programs to touch those patients on the outpatient basis, but they generally fell short of our expectations. We realized that we needed a partner to be able to reach into patients' homes, to touch them and to be able to create points with them that could ultimately impact and change the delivery of care that we currently give. Actually, the nice thing about the Agilon partnership is that we've been exposed in the past to a variety of programs that were developed by health plans, which for the most part were health care maintenance policies, and we felt that we needed disease-specific policies to address our patients' needs. We in conjunction with Agilon have been able to create models of care that we direct and we change. And so we created a model. We created a cure management program. We roll it out and if we as physicians don't like it, we don't think it's achieving the goals that we want. We just reinvent it because we own it and we're responsible for it. We're arrogant enough to believe that we're primary care physicians. We know we think what's best for our patients.

And so our ability to change the model on the fly to make sure that we're meeting the needs of our patients was a critical decision for us in the partnership with Agilon.

Q

Thank you, Dr. [indiscernible] , Dr. Kornitzer can you tell us a little bit about your practice and why you decided to partner with Agilon?

A

Sure, Ben. I'm an internist and a member of an independent practice association made up of 40 independent primary care physicians scattered across four counties in rural southeast Ohio. As a third generation physician in my family's medical practice, I saw firsthand what health care should be. As a boy and then later on as a young doctor, I worked side by side with my dad. I saw him making house calls on evenings and weekends. He spent countless nights, sleepless nights in the ICU, taking care of his sickest patients, and he always took the extra time it needed that that patient needed a complex patient needed in the office, no matter how hopelessly he was behind the office to dad there was only one patient on his attribution list, and that was the patient in the room with him right then. I'm the primary care physician now for Dana, an 84 year old, and she loves to tell a story about when she was a child and felt very sick. My grandfather went to the home to care for her. When she woke up in the morning, he was asleep on the floor at the foot of her bed. But then health care devolved to survive, we had to see more and more patients and less and less time.

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Meanwhile, our patients are getting sicker and older with more complex social issues. It was untenable it was a system that was broken, it wasn't good for us as physicians and it absolutely wasn't good for our patients and we knew it. Look, we didn't want another tech vendor, we didn't want a management consultant, okay, and we didn't want a hospital system coming in and buying our practices what we needed was a novel business model. We needed a partner. They could align financial success with what we knew as doctors was best for our patients, spending more time with them, more individualized care and creating embedded care teams to take care of them. That's why we partnered with Agilon Health.

Unverified Participant

Thank you, Dr. [indiscernible] I wanted to say, we were talking a little bit earlier, right, and I said, did you ever think when you were graduating medical school or practicing in rural Ohio that you'd be sitting on a panel on an investor day in New York and you said, listen as PCPs, we've always done well takes improved care for our patients. And if this is part of it, I'm actually going to be there. And so, everyone that you see here, right, none of them are spokespeople. They're all frontline PCPs. But I think that sort of authenticity and passion and let the experience really speaks volumes for our model. So the next day I'd love to understand is how has this partnership allowed you to practice differently? So again, Dr. Spencer, while you walk us through what that's been like in Austin?

A

Yeah. I think I've just been amazed by what you heard from Girish and Dana, the insights and the ability to really understand what we can do to impact our communities. And, frank will talk to you and you've heard what we can do within the PCP offices better. We can see our sickest patients more often. We can do a transition of care right when they get out of a facility. But what's been so empowering is our ability to influence the total cost of care. So take renal patients. Renal patients are some of our very sickest patients. Many of them are at any stage or on dialysis. They have a lot of comorbidities. We were able to see in our market that we were one of the worst Agilon markets around renal care and renal spin. That wasn't because our nephrology colleagues in the market are bad doctors there in a fee for service model, they didn't create the care around the patient. So we've been able to partner with a third party that does this extremely well. And we have a medical actuary team and And we have a medical actuary team and we have a, medical finance team that can help us to make the right deal with this party third party. So not only are we guaranteeing a savings on a patient base that we used to lose on from a cost. What I care about is two things as a physician, one is our patients are now having optimal starts for dialysis in our market. They're not crashing in to the hospital to get that kind of care where complications are high. They have real renal, renal trained care management nurses going to their home, going, going and interacting with them and bubble wrapping this very sick group of people and patients are getting better outcomes.

You know, renal patients, some of them shouldn't go on dialysis, they're so sick that dialysis does not prolong their life, they were never getting end of life discussion to have dignity, to decide how they want to pursue their health in this area. Because, you know, the business model was that the nephrologist owned the dialysis center and, and it's easier to put folks on dialysis, not from not because they're trying to do the wrong thing. It's just that's the way the model worked. So we, we went to this nephrology group as, as the delivery care model in our market and in a very collaborative way, but in a very assertive way, said this, this is the way we're going to care for our renal patients. Remind you, this is a group of patients that we don't see very much, most of the time they're under the care of the nephrologist and they no longer come to the primary care, yet we've changed their care in our market based on our size or influence, the model that we're in and the partnership with Agilon. So it's just empowering to say not only did we need to do things better in the PCP office, we did and we are, but we have

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other things in other areas that we're able to influence around other parts of the care that we never would have been able to do without the Agilon partnership, the type of model that we're in and the alignment that we have.

Q

Dr. Spencer, this is a follow up question right now, given the fact that there's commonality among senior patients that we have multiple partners who are sort of thinking through similar issues, can you share any of the learnings that you've had or the benefits of the platform in the network as you've thought about this opportunity?

A

Absolutely. I mean, so that example that I'm talking about in Austin, Texas, is going on in 5 different Agilon markets today, and probably the other 15 will be added because this makes a lot of sense. So, Frank, Pat, Bill, others, we collaborate commonly and often around all of these issues. So again, Girish and Data are delivering the same view across the entire network. So the medical directors, the physician leaders, the market teams in the markets, we're talking about a lot of these same consistent issues that happen across markets.

Q

Thank you, Dr. Spencer. And Dr. Salvatore, you're talking over the week, I know you were just in service and one of the things that came up that seems very different to me, right, is how you're really dealing with transitions as patients navigate different parts of their acute episode. So you want to sort of share how this has been different in your market?

A

So Ben was referencing of the fact that yesterday I got texted by our hospitals that their census was 21 and they needed help rounding. So fortunately, my partners were on the group text, so they helped around in the hospital this morning. I could speak to a variety of value-adds that we've benefited from with the partnership with Agilon, but I think I'll probably just focus on one concrete example and I'll call it the transition of care cascade. And so nationally, we've recognized as physicians that as patients transition from one care system to another, whether it be from the hospital to the nursing home, the nursing home to the rehab unit, the hospital to home or home to the hospital, all of those transitions place the care – place the patient in a very vulnerable position because there's potential for errors in medication reconciliation, for inability to deliver outpatient services that were intended and so as physicians prior to our relationship with Agilon I would be in the office, I would see a patient and I would -- I would ask them, well, have you been for the last three months? And they said, well, I was admitted to the hospital across town and I had a surgery and then I went to the nursing home and I ended up with a complication in the nursing home and went back to the hospital and I had a two week stay in the hospital and then I went to a rehab unit and I got discharged, and here I am now. And so it was really frustrating because I'm their primary care physician and I had little or no ability to impact that transition and so our partnership with Agilon we now have software which I euphemistically call Where's Waldo? And we have a dedicated RM that monitors this software and we get daily real-time ADT feeds admission, discharge and transfer feeds on all 20,000 of our Medicare patients. No matter where they're at in the city and our RM monitors that software and reaches out to those patients that day when she sees it, to talk to them, to find out how their care is progressing, what potential needs they might have in the transition of care from eventually when they're discharged from the hospital.

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For those patients that we take care of in the hospital and we are primarily responsible for, we have daily conversations as I -- as I did in the text yesterday with our hospitalist in regards to the progress of each of our patients in the hospital. At the time of discharge our hospitalist has a communication with our transition of care nurse. That transition of care nurse understands all of the medications that have been changed, those that have been stopped, those who have been started, the procedures that have been done and also all of the interventions that the hospitalist intends for that patient as they transition to the outpatient setting. So if they're going home, do they need home oxygen, do they need DME equipment and ultimately, do they need home care. On the day of discharge, our transition of care nurse then calls that patient and make sure that every, all of the intended interventions that our hospitalist has written for have been completed, so she speaks with the patient and says these are the oxygen there, did the hospital bed arrived and during the course of that visit at the end of the visit as she reconciles the medications to make sure they're accurate, she then schedules a follow up appointment with me within 48 hours of the discharge. By the same token, we have with the aid of Girish and Dr. Kornitzer has been able to do a rigorous review of the post-acute care facilities that are within our catchment area and we've looked at them from quality and cost standpoint and we've tiered them. And so we have Tier 1, Tier 2 and Tier 3 facilities and we preferentially discharged with the aid of our hospitalist and our transition of care nurse, our discharge of those patients to Tier 1 facilities. Why do we do that? Well, those facilities historically have provided better care at a lower cost. But also more importantly, we found out that those facilities have our physicians on staff. So our physicians are taking care of our patients. And what we found is that if we discharge our patients to a Tier 1 facility, our costs, our episode of cost for 90 days is $4,000 less. Our outcomes are better, our for 90 days is $4,000 less. Our outcomes are better, our readmission rate to nursing home to hospital or readmission rate from home back to hospital from the nursing home is markedly decreased. It makes sense our physicians know our patients. Our physicians have a vested interest in their care. So the care they are delivered is better. It's more efficient and it's more timely. And the nice thing about it is that we now feel like we're back in control of our patients. We're now the quarterbacks of their care. We feel that we're the most appropriate people to manage that care through the transitions of their healthcare.

Q

Thank you, doctor. It's been really just inspiring to see the transformation that you've led in the Pittsburgh market. So Dr. Goggin you come from rural southeast Ohio, you have a large high risk population, how is the partnership really allowed you to practice differently?

A

I think the best example is our current high risk patient care project and I want to describe that like the before and after as it pertains to this project. Any full time primary care doctor can tell you who their sick patients are. They could name their top 10 or 15 sickest patients off the top of their heads. But what we didn't know, what we didn't know. We didn't have embedded analytics at the point of care to tell us when they were getting sick. And as Frank mentioned, we often didn't know that they were in the ER last night or that they're currently in the hospital the next county over. Even if a patient would reach out to us and let us know that they were sick, we hadn't built the flexibility and scheduling to provide access to be able to see them right then and to provide the time they needed to keep them out of the ER. It felt like our care for them was always reactionary, always putting out fires. Now what we're seeing as we have advanced analytics at the point of care, this is identifying our high risk patients. It's identifying for us their most threatening risks. We are hopping off the treadmill of fee for service and redesigning our schedules so that we have more time to spend with these sickest patients now that we've identified them and we're building a highly coordinated embedded care team to help us care for them. In essence, what started in the 1930s with my grandparents making house calls to homes and farms across Guernsey County has evolved to the

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point that now we have a highly integrated team physicians, advanced practice providers, our own NK care managers, clinical pharmacist, social workers. And in an ironic turn now 90 years later, we're returning to the home where we've built a home visit program and we're taking palliative care services to our most vulnerable and sick patients where they need the care it's – is very impactful.

Q

And I know it's very impactful and it's also you know very inspiring that we were on a Zoom call and you actually showed me at the house you're living in is the same house that your grandfather, who was a family practitioner in the same community lived in so I think that really speaks to the long-term relationships and trust. And you'll find the way I'd love to sort of understand is everything we do we do you know through either our doctors or through patients, right? And so you know let's start with Dr. Spencer again you know what is the impact of this partnership been you know on your physicians and on their patients?

A

Yeah, it really nagged me as a physician leader of our group, you know, you began to see physician burnout, you began to see them lose their hope that the mission that we all went into the field for was not being accomplished. We inherently knew that we were doing a good job in front of that patient for 20 minutes, but we weren't necessarily impacting their overall course. And so you know we've really seen physician burnout improved. We've been able to see less patients per day and spend more time with patients. We're hearing from our patients we do survey our patients, listen to our patients and they – they're you know, 94% of them feel like in this model of care that they're receiving, you know, high value care and getting what they need from their physician office. We're really proud of that. So honestly, we're – we're able to hire physicians better. You know, we – before we were unable to hire at the pace that the market – in the market share that we could have taken. We didn't have the capital or the business model. So, we're – we're hiring great young physicians who are excited about practicing in this model. And then our older physicians are able to slow down and get off the treadmill and spend the time that they need, because all the analytics are great, but their only great if we can actually impact the life in front of us with that. And that takes time and thought and a plan. And so they're more professionally satisfied.

Q

Thank you, Dr. Spencer. So, you actually brought a very interesting point in terms of growth, right. And so maybe we'll go to Dr. Goggin next. So, as you think about the impact on physicians, on patients, I know that you've had, you know, significant growth and in your own market. Can you talk through that and – and how that's impacted your – your physicians?

A

Ben, I'm more optimistic about primary care now than at any other time in my career. I mean, just two or three years ago, our group, although we were good at a lot of things, we were highly fragmented. Across 25 practices, we had eight or 10 electronic health records. We had five practices still on paper. We're all working and toiling away on our own, doing it our own way without a real line of sight into our patients and their risks. Now we've been able to stay independent, but more importantly, we're interdependent. Our physicians are more highly engaged now than ever. They're invested in this partnership, and that's allowed them and empowered them to – to jump off that fee for service treadmill, roll up their sleeves and – and help work with our partners to develop the

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clinical programs that we need to improve the care for our communities. And in the health care community in our areas took note notice, like just last year, a 14 physician primary care practice left their employed model with the primary hospital system in our network and joined Left their employed model with the primary hospital system in our network and joined us in this endeavor as partners and our IPA grew by 40%. That's also an outcome I could not have imagined two or three years ago.

Q

That was actually remarkable. And Dr. Salvatore, can you talk a little about the impact for your physicians and patients.

A

Sure. As I was thinking about how I was going to answer the question, I thought this is going to sound really ironic. But the partnership with Agilon has given us more control over our practice and that sounds kind of anachronistic, but we felt for the longest time that even though we were autonomous and an independent physician group, we were losing control over the over the care of our patients. And I think the partnership, as has actually given us back control, as I highlighted with the transition of care, but also as importantly, to speak to some of the comments that Girish and Dana made, for years, we were -- we had access to data that was pushed down to us from the health plans. The vast majority of that data was oftentimes invalid and it was not actionable and the beauty of this model is that with Dana and Girish and my partner [indiscernible] 02:09:10 who is a technology geek in addition to a physician, they've created a team of people that actually look at data critically from a physician's viewpoint and the ability of that team to synthesize data and actually present us data that's actionable that we can validate. And the nice thing about it now is that our physicians and I believe the other partner groups actually trust the data that's now coming from Agilon and from our partner.

And with that data, we feel once again that we now have control and we'll have future control over our patients as opposed to the model that we were engaged in prior to the partnership.

Unverified Participant

Okay. Thanks.

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QUESTION AND ANSWER SECTION

A

Minutes of Q&A, but I do just want to thank you all so much for being here. It's great to have you. So, we – again, we've got a couple of mic runners. So if you just raise your hand, we'll get a mic over to you. Lisa, I saw you first.

Q

Lisa Gill with JPMorgan. I always have lots of question. So we're all financial analysts, so we think about things from the finance side. So first off, can you talk about the economics of your practice and what Agilon has been able to bring from that perspective? And then secondly, you know, one of the things that really resonated with me was losing control of the patient. When you talked about previously, even though you were autonomous, was that lost to the health systems? And if so, are you feeling any pushback? I know we talked about meeting earlier, but are you feeling pushback from the health systems that you know we really enjoyed when your person came to the emergency room and spent longer in the hospital than they should have?

A

You know, Lisa, first of all, thank you. Thank you so much for the question. I mean, why don't we start with, you know, Dr. Spencer, right? So in your market, you know, in Austin, we would be very curious, so how are you reinvesting the economics? You know, Ben Shaker spoke earlier about one of the ways we as an organization sort of measure ourselves. Or are we to turn those economics to the physicians? And what's it meaning for their practice? And also, you know, you certainly have a market with significant density, in terms of specialty care, in terms of hospitals. And so what that relationship has been like?

A

Yeah. I mean, I think – I think on the economics of the situation in this business model, we're able to invest ahead of the outcome now. So physicians are earning more. But a big piece of this is to reinvest in the clinical care because as we pointed out earlier, we are because as we pointed out earlier, we are -- we are having success in these early years but there is a lot more there to go get and the only way to get that is to invest in the clinical care of our patients. So things that we invest in or our nursing care management, pharmacist, we didn't have that before social workers. We were -- we interact more closely with the health plan around our dual eligible patients so that the community resources and some of the health plan resources that used to feel fragmented. We're working with our payer partners unlock that.

So we're able to hire physicians and pay competitive salaries in our market against the health system, so that's what we're seeing economically. As far as the health systems go. It's the more you learn and get into this business, it's very interesting. They really actually don't make money on sick Medicare patients with medical DRG diagnosis sitting in their hospital, their [indiscernible] surveys, quality surveys go down. Their ERs are full. It's not what -- It's not what they do. So they actually welcome us. We've embedded nurses and nurse practitioners in the ER who meet our patients there.

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So our patients that feels like a white gloved, incredible experience. Their ER is getting better service because it feels like they're delivering a different product when it's really us and we're keeping the medical patients out. The patients who need heart surgery and need things like that those are the patients that are designed. So, now we're in a growing market in Austin with the bed capacity pretty full. So we're actually pretty aligned around that. That's what we're experiencing in our work.

A

Lisa I want to go to Stephen, he is right next to you.

Q

Okay

Q

All right. Thanks. Baxter Steve, Wells Fargo. So it seems like your model would be, you know, extremely well positioned to benefit from biosimilar competition as physicians. I was hoping you could talk about what you're doing operationally to be ready for biosimilars and I guess how much of a priority is this for you versus other areas potential savings you're exploring in the future?

Q

Yeah so I think the other question, if you clarify if I just sort of expand it just beyond just biosimilars, but very probably in terms of drugs, the expense you don't want to pick on you with every single question, but I do know that that's something in terms of high cost specialty medications that you've specifically looked in your market. I don't know if you want to walk through that example?

A

Yeah, I mean, we've looked at the Part B drug costs, Part D drug cost as it relates to that. And first and foremost it gets back to low value care and high value care. So there are certainly patients that will need certain medications where that can really impact their care. But we also know and we share this with our specialty partners in our market that there's patients who don't benefit from that. There's also patient exposure for that that we work on to do that. We also work in research and try to get a lot of these patients into a research study. Our groups are – and our markets at scale so we have access to the research dollars that often then it's not adding to the total cost of care of the patient. It's not adding to the total cost of care of the market. And so those are different ways that we've looked at that. But honestly we put the patient first and if they need a therapy that's expensive they need a therapy that's expensive. There is so much inherent waste and inefficiency in the system before we have to go to any specific drug, we're attacking more of the overall problem. So yes there will there will be new therapies that come out that patients need and we want we want our patients to have those because it can impact their life and prolong their life but that's how I think I would answer.

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A

Why don't we go to George Hill right behind Stephen?

Q

We're playing pass the mic today, I like it. Good morning, guys. George Hill from Deutsche Bank. What I'm interested in hearing from the practice side is could you talk about, could you quantify, tell us, what are the quantifiable performance metrics you guys use to measure your relationship with Agilon and then please talk about how you're performing against those metrics?

A

Great. So Dr. [indiscernible] , would you like to sort of take it also? So, you know, how are you seeing that prioritize? How he's setting your priorities and how are you sort of measuring yourself? I know that we talked about the high risk patients sample. I know that's an area that you're focusing on that you've set sort of very specific metrics on.

A

I think the primary metrics we're looking at are meaningful health outcomes for our patients. So ED admissions, hospitalizations, readmissions, what can we do to control those metrics? So the enterprise analytics team not -- not only delivers those metrics to us, but they've helped develop systems so that we're not waiting on claims data to bring that delayed information. We need real time data every day. And so they've interfaced with our electronic health records around scheduling of visits, closing care gaps and these utilization metrics so that we can measure that on a day to day basis and then take that back to our clinical operatives teams to -- to refine on a week to week basis what we're doing and how to improve the care for our patients.

Q

Yeah. Absolutely.

A

And I just [indiscernible] comment I would only say that this is a more generic comment. The reference was to how do you -- how do you benchmark it against Agilon and/or how we're performing for Agilon. When we initiated our market in Pittsburgh I said euphemistically to everybody, Agilon is a four letter word. We're not going to use it here. As PPCP is a four letter word we're not going to use it here. We created an entity called Preferred Senior Care Advantage with Agilon. They are our partners. We own this business together. So there's no such thing as it's the Agilon team or it's the preferred primary care physician team.

It's the preferred senior care advantage team. And so we believe we're true partners. We act that way. And to date, the performance of our organization in conjunction with Agilon to create this new entity has been engaging and inspiring for us, as physicians. So physicians are always suspicious of partnerships because partnerships

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with specialists and health plans generally end poorly. And but our relationship has been as pure as a partnership can be.

A

Why don't we take one more question? Please go ahead.

Q

Kris Jenner, Rock Springs Capital. Dr. Spencer, you shared an example of best practices that started in your market in Austin related to the care of [ph] SRB. And then, if I understood what you said correctly, it was then disseminated broadly. As I listened to all of you, it's very, very clear that Agilon partnership is very impactful, to you locally and to providing better care. But I was wondering if you could provide like additional examples. Any one of the physician panelist could provide additional examples of best practices that has been broadly disseminated from whether it be Wilmington, North Carolina or Austin or Southeast Ohio or Western Pennsylvania. That speaks directly to, AHA's in terms of providing better care locally, but actually originated outside of your market, but was provided to you, as another powerful example of the benefits of an Agilon partnership? Thank you.

A

Yeah.

of the benefits of an Agilon partnership? Thank you.

A

Yeah. I mean I think I would answer that in a couple ways, one, one is there are some things that aren't very aha, that we, that we just needed to better. So, Dana and Girish bring us things like, you need to see your [indiscernible] 02:19:55 15% of patients, five, six, seven times per year, you are busy physicians and you can't get them on schedule so how do you operationalize that. so, the best practices was less about what kind of innovative clinical care and it was more around how do you operationalize that back to, we have different types of partners, different sizes, different locales, so I always can go find someone that looks and feels just like me, and we can compare notes on the operation side. So, one, this business is a lot about execution more than I ever realized as a doctor than it is necessarily about innovative care. So, I would say that as, as one thing that we're learning. So, to be data-driven, look at the KPIs, drive towards those, have doctors understand why something that feels so businesslike is actually so important to the health of your patient is one big thing.

The other is, the other, other examples, people are doing innovative things. So, we have had markets from Austin who was doing a home visit program, share that with Columbus. Columbus, who was doing an extensive care clinic, has shared that multiple markets. A great one that we're working on across the entire system and, and what I really like about the Agilon management team led by Steve and Steve preaches this is there's, we're developing a product at the enterprise level. So yes, we do learn from all of our local partners who are great partners and are doing innovative things. But take palliative care, Buffalo and Akron were working on palliative care. Now, we have a palliative care end-of-life approach that we're trying to, to bring that all of us are studying across all the markets. So, there's an actual, what does the staffing look like, what is the model so there's an actual what is the staffing

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look like, what is the model, what are the touch points, what's the conversation need to be in the room to get patients to be willing to have that kind of discussion that feels like giving and dignified and not scaring them into saying, you're about down to that level of detail, that's all codified now. So when another market wants to say, Hey, so you not only have it from our product team that can project, manage to run, run the playbook in the market for our patients, I can pick up the phone and call Frank, and say Frank what were the issues that you had? What – how did your physicians respond? How do we move this over the finish line? So that's the kind of cross-pollination, but I've been very interested as a physician to say, you know, there are a lot of innovative clinical things that we need to be doing differently. But there was also just a lot of execution at the practice level. We were all running pretty successful businesses and we've all learned we can be a lot better just on run on doing the main things well.

A

I think we have to get it there. We love to celebrate our partners at Agilon, so if you could please join me in thanking. Thanks again.

Q

All right. It's my pleasure to introduce you to Heidi Hittner, our Chief Experience Officer to discuss stakeholder impact.

A

Thank you, Matt. Good morning. Thank you all for being here. We really appreciate the opportunity to share our story with you. I'm Heidi Hittner. I'm Heidi Hittner, and I've been with Agilon since nearly the beginning, starting with the class of 2019. I've had the opportunity to work with our physician partners and our markets and enjoy the opportunities we're expanding I've had the opportunity to work with our physician partners and our markets and enjoy the opportunities we're expanding and rapidly growing the platform. You just heard from our physician panel about the difference our Agilon model has made for them and their physician practice. And now I'd like to share with you how our other stakeholders our payers, patients and communities as we're able to move the market to value at scale are also benefiting from the Agilon model. Payers benefit from our Agilon model in three key ways. The first thing is we create scalable partnerships. Starting with CMS the largest payer, CMS has stated their goal of having a 100% of seniors in total cost models by 2030. We have national relationships and we meet with our national relationships, plus CMMI leaders on a quarterly basis. We had 16 joint operating committee meetings last year and we have 16 on the calendar already in 2022. Our national payors tell us that our JOCs elevate our relationship with them in a way they don't experience with other providers. We're learning labs with those payors who can continually help to evolve the model.

And we have 20 health plan contracts nationally. Two-thirds of our 2022 membership is covered by these national relationships. They are scalable. We're on standard paper, standard data sharing agreements, and that allows us to move very rapidly into new geographies. So as we expand with new partners, we can move very quickly with these national relationships. The regional payors are very important to us to. Two-thirds of our markets have a regional payor, and those regional payors have deep, long-standing relationships in their markets and with our physician partners who have been in those communities for a long time.

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With limited exception, however, we are the first global risk arrangement those regional payers have ever been in. And so we have to provide the tools, the framework, the structure that's needed to move into a global risk arrangement. How do you support a partner in being successful? And we're able to bring that capability to our regional payers. Both are important to us that ability to help them to move to value. Our payers also benefit because of enhanced quality and benefit design. Our physician partners deliver phenomenal quality outcomes four and five star Medicare preventive ratings, but we also give our payers something to talk about that goes just beyond the supplemental value of the benefits that they offer, because together through the lens of their primary care physician, we enhance their quality strategies with the way that we're able to help patients in engaging with their benefits. We're really good partners. We know that patients who engage with their benefits are stickier with the health plan. And so every new patient as they join the program, they get materials from their primary care physician helping to ensure that they know how to engage with their benefits. Some of the health plans offer gift cards for getting your annual wellness visit or your colonoscopy, your mammogram, and we make it easy for patients to ensure that they engage with those benefits and learn about the options. Payers are also winning because of our predictable and optimized economics. We grow 1.5 to 2 times market growth in these non-traditional PPO geographies. Payers lock in a consistent gross margin to de-risk their business. And especially in the PPO space we have a much more extensive and mature attribution playbook to help to progress payers both national and especially regional in moving to take PPO risk were the catalyst for them to develop processes, systems and support to manage PPO risk. So payers benefit from this growth in these non-traditional geographies outside of Southern California and South Florida your traditional, you know, kind of value-based care markets, PPOs in those markets only 6% to 10% right, the national state as much higher and in our markets, 50% of our business as PPO. And we've demonstrated consistently that in those local communities, we are able to grow and help our payers grow one and a half to two times market rate. and we're able to do that to create a single experience for the patient in a way that no one payer could do because we have the opportunity and the ability to communicate with patients through the lens of their primary care provider.

We know who those patients are – we can quantify that. We know we have 100,000 patients today on commercial insurance who are Medicare eligible, and we're able to engage with those patients throughout the year with unique educational opportunities to learn about their Medicare options. We know we have another 165,000 patients who are aging into Medicare over the next five years. And today on the platform, existing patients within our partners practice there are 200,000 traditional Medicare patients. We engage with those patients on a consistent schedule weekly during the annual enrollment period. We sent over a million pieces of communication last year during EAP – and it's all templated. It's replicable, it's scalable. It's standard customization. It's through the lens of their primary care provider, but it's their local brand. It comes from their local doctor. So patients get to experience the relationship, they've already had long standing relationship with their primary care physician, and now it's enhanced, the average tenure of our primary care physicians is 11 years. They've been with these patients for a long time, and that trusted relationship shows up in the way that patients rely on their primary care provider for who to seek for care. 89% of our patients rely on their primary care physician for recommendations on which specialists to see. And as we're engaging with frontline physicians like you just heard from our physician panel, we know through our analytics and data insight that frequent touches to certain patients at key times matter.

It allows our physicians to see their high risk patients with 44% more touches than non-high risk patients and even partners who only been on the platform for a short time. You got to hear Dr. [indiscernible] 02:30:30 in Pittsburgh. We know that they already see their patients who've been in the hospital 48 hours post discharge twice the national average. Patients get to have not just an educational model about their clinical care, but they also get to learn about their options for health equity. We know there's more comprehensive benefits offered through Medicare Advantage. Many of the MA programs have meals available post hospitalization to ensure patients remain healthy. They offer rewards for healthy behaviors. We just created a 10 minute, 12 week video series

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about patients specifically focused for seniors on the benefits of remaining physically active all through the lens of their primary care physician.

And many of our payer partners have rewards for patients for engaging in those healthy behaviors. So that shows up for patients in this industry leading patient experience.

I'm sure you're all familiar with the Net Promoter score, right? The likely to recommend question, it runs from negative 100 to positive 100 as the score you can get, we're really proud of the 80 net promoter score that our practices have. We're also very proud of the voice that our patients tell us 94% believe that they get comprehensive high quality care from their primary care physician, and they are sticking with that provider. 94% of patients also tell us they plan to remain with their primary care provider. Patients see better outcomes in their health. We look at that from the lens of preventive care, chronic care management and also overall health for the annual wellness visit. For cancer screenings, breast cancer, colorectal cancer screening 18% better than the national average, 82% is a five star rating. Medication adherence especially for chronic disease is critically important. We see nearly 80% better than benchmark on adherence for medications around high blood pressure, high cholesterol, diabetes. And for patients who have cardiovascular disease or diabetes, the importance of being on a statin nearly 40% better than benchmark. What really pulls it all together, though, is that annual wellness visit. The ability to spend time with their primary care physician focused on preventive care, laying out a plan for their overall health and wellness, charting a course to ensure that those patients have more healthy days than sick days. We're really proud of the ability to be nearly 100% better than benchmark in our annual wellness visits. These healthy patients create healthy communities, our communities benefit from increased access and capacity to primary care. We're located in areas that serve the underserved population and because of our scale and our mindshare and the presence that we have in that local community, we are able to help to move that community and the local delivery system to value. So, how does that show up for access? 89% of our PCPs have panels open to new seniors. That's 25% better than the national average at 70%. And in a pandemic over the last 12 months, our physician practices have invested in new primary care capacity, increasing by six percent. And now we have access. We have capacity. And because we're contracted with 85% of the leading plans in that market plus CMS, patients have a real choice. 43% of our payer of our PCP locations are located in federally designated underserved communities. You heard Steve talk about our partners and our non-traditional geographies that we enter Southeast, Ohio. You heard from Dr. Goggin, we're in East Texas. Pinehurst, North Carolina. CMS has recently talked about the expansion of the ACO program with reach, with the goal of health equity and access, and we are very aligned and supported with that. And finally, because of our scale and the mindshare of the primary care physician, I imagine you're getting all of your data about your senior population now from all of your MA plans in one spot. You combine that with your EMR data like Dr. Korn talked about. Now, you have the ability to see a view of your senior panel and their holistic journey you never had access to before. And it's simple, it's all in one spot that you can access that. And so, we are able to move the community to value in 6 of our 15 markets, covering 56% of our lives we are larger than the largest single payer covering 56% of our lives, we are larger than the larger single payer. And even in markets, where we aren't the largest our primary care physicians are key referral source in the local delivery system. You heard Dr. Spencer talk about how they engage with the specialists. Dr. Suruchi talk about how they engage with their post-acute facilities, how they're really able to make an impact in moving the entire delivery system to value. And that shows up in a reduced burden to that local communities healthcare delivery system. We see a 30% reduction in readmission rates, 14% decrease in our inpatient rates and in our Columbus market in those last key 90 days before death and 58% reduction in spend. So you can see three key things that are a benefit to our stakeholders, the communities benefit from moving to value and we're able to do that at scale, our payers are benefiting from above market growth in non-traditional geographies, and I'd like you to hear directly from one of our patients, Gary in Pittsburgh. His primary care physician is Dr. Doshi, and I'd like you to hear from Gary how the Agilon partnership has changed his lifem, his wife and even his extended family.

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Unverified Participant

Gary was diagnosed with the atrial fibrillation with congestive heart failure COPD, which would cause shortness of breath. He couldn't walk more than a few feet. He just couldn't do much of anything.

Unverified Participant

When you can't do it no more, you feel useless. In the beginning, he had the problem with the hyperthyroidism COPD and [indiscernible] 02:37:07 but then he translated into diagnosis of multiple myeloma and amyloidosis. He was told in the hospital about the end of life care. I did not agree personally because I think he has things to see and leave for – if the medical treatment and with the help of complex care management medical treatment and with the help of complex care management, the program for Medicare Advantage patients created in partnership with Agilon Health. We can provide better care and close monitoring and that should help him to get better.

Unverified Participant

Each day I talked to Fran and Gary, and I did an assessment of mental health and his physical health through listening I was able to decipher what they [audio gap] (02:37:42) plan not for them, but with them. We set daily goals of exercising on the treadmill and eating a healthy diet. Our weekly objectives were to give him more responsibilities around the house as our relationship progressed we found ways to make Gary have a sense of purpose.

Unverified Participant

This new program helped us to keep him out of the hospital at least 17 times in the last two years. It's an example of our patient centered care approach that was solidified with the help of Agilon Health.

Unverified Participant

We have been on vacation for 14 years and I was talking with Dr. Joshi, everything was put together to the point where we could actually go...

Unverified Participant

Just for as short as every day you'll be fine. You're going to go you're going to enjoy your time with your grandchildren and we did, we did. We had a wonderful time. Thanks to her.

Unverified Participant

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Along with treating their medical condition, if you take care of the mind, you can take care of the thought process that translates into the better mental and physical health. All those things would not have been possible without getting help from the support staff and the chronic care management program.

Unverified Participant

Because of the care I've gotten from Dr. Joshi and my voice and everything they've helped me with I feel better than I have in years.

Unverified Participant

To know that you're faced with these life threatening diseases but there's somebody there always who thinks about us offers us hope, a lot of hope.

Unverified Participant

Wasn't that powerful?

that was one of the first programs that Dr. [indiscernible] (02:39:24) practice was able to invest in, because of the Agilon partnership. I'd like to introduce you now to Tim Bensley, our Chief Financial Officer.

Unverified Participant

Well, thank you, Heidi, and good morning, everyone. I'm Tim Bensley, Agilon Chief Financial Officer. I joined Agilon in January of 2020 right before the IPO, and I brought with me 30 plus years of experience building and scaling finance organizations and a public company environment. And I think maybe just before I jump into my slides, I'm going to say after listening to my Agilon colleagues and our physician partners this morning, I'm just really, really excited to be part of this very impressive team. Okay. Three key themes that I hope you can take away from my presentation today. First, with the strong growth that we've seen in membership through 2021 expected to continue in 2022 and beyond. We're really happy that at the same time, we've been able to grow medical margins, both at the market level and at the member cohort level as those members mature on the Agilon platform. We deliver that growth through a leverageable capital light partnership model that drives significant returns on capital. And we have high visibility and confidence into our long-term outlook, which we believe is going to benefit from the record growth in both numbers and diversity for geographies, partners, members and PCPs in our class of 2023.

The Agilon economic model really is driven by four key attributes. We enter into long term partnerships long term 20-year partnerships with leading PCP groups. We have very high visibility into both future revenues and margins, because we enter markets through existing capacity. We have a very capital light model with extremely low customer acquisition cost, I'll talk more about that later and with 60% of our membership having been on the platform for less than three years, we have significant embedded in margins that we're able to access over the long-term as our members mature on the platform. All of that sits on top of a very light overhead model, driving significant leverage.

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We've had a lot of momentum since our exception – since the company's inception in 2017, and we have a high level of confidence in our 2022 guidance, now that includes our expectation to improve overall membership by over 100,000 members in 2022 to about 350,000 members that includes both through contracting and MA and that will result in about $2.5 billion in revenue. Now, we have a lot of confidence in that membership growth number for a couple of reasons. First of all, 50,000 of those members are the new MA members that'll come on board because the six new geographies that went live in January of this year, there's another 35,000 or so members in new direct contracting members that also went live in January and then we expect to drive 13% to 15% same geography growth, and that is very consistent with our recent relevant with their last two years historical performance.

We're also going to show significant improvement in medical margin growing overall medical margin dollars more than $120 million to about $300 million in 2022. Most of that growth is going to come from markets that were on the platform in 2021 and before, you take that growth in medical margin in combination with the continued leverage against our platform support costs and an expectation that direct contracting will be a modest positive contributor to adjusted EBITDA leads us to a 2020 where we'll move to a positive overall adjusted EBITDA for Agilon an improvement of $40 million to $50 million on a year-over-year basis.

So let's break that down into a few of the drivers of that growth.

if you look at the top of the slide box in Red. You can see that we have an expectation that those markets that have been on the platform – of those partners in markets have been on the platform in 2021 and before are going to drive significant improvements in medical margin from – and by the way, that group represents about 63% of our overall membership.

They'll go from about a $94 medical margin that we delivered across those markets in 2021, up to $127 to $130 medical margin PMPM. And that's going to drive more than 80% of our overall medical margin for year. Now, our new partners, which represents that about 50,000 members coming on board in those six new geographies, we're going to start at a lower rate of about $36 to $37 medical margin PMPM and obviously be a lower contributor to our overall medical margin growth in 2022. But with 50,000 members, that brings a lot of embedded margin that there will then be developing over the next two-plus-years. And then our non-partner market of Hawaii, which I'll talk a bit more about later, doesn't really benefit from the alignment of our partnership models and so it operates at a lower medical margin PMPM about $46 but with some of the improvements and programs we're implementing there. This year, we expect that we'll see improvement pretty significant up to $56 to $58 of medical margin PMPM and that Hawaii should be a contributor to our year-over-year, both medical margin increase and adjusted EBITDA growth.

As Ben Shaker talked about earlier, we've seen really a strong medical margin progression at a market level across our markets. So let's start with some of our more mature markets. And on the left hand side, our most mature market that we went live with in 2018 with about 25,000 members and a very robust $133 medical margin PMPM. We've seen tremendous growth in membership, growing more than 70% to 42,000 members expected in 2022. And notwithstanding the dilution of that, those new members, as they come on the platform, we've seen steady, progressive, steady medical margin progression up to $150 in year four, and we're expecting to see about $170 in this market in year five, which is 2022. I will point out that that circle that one outlier year is, of course, 2020, which was significantly impacted by COVID utilization suppression.

The year for market example, next to it, starting at a lower level of $40 medical margin PMPM, its second year was actually that year where we had some COVID suppressed utilization, but it continued to progress beyond that, delivering $186 medical margin PMPM in year three, and we expect it to progress even further in year four.

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And I really think this market's pretty impressive because the year $386 PMPM is even greater than what they saw during that year of COVID suppressed utilization.

Looking at a few of the newer markets and particularly this year, three market is impressive and we started with 14,000 members in 2020, which, of course, you know, started with a pretty high medical margin dollar because of the COVID suppressed utilization, but was able to even grow out of that to over $200. And we expected to maintain a medical margin PMPM of over $200 going into 2022 as well.

Now, up to this point, I've really been talking about medical margin at a market level, which includes, as I said that dilution from new members as they come onto the platform in each of those markets. But I think it's really helpful to look at medical margin through the lens of annual member cohorts, which then removes that dilution from the equation.

So here is our first annual cord that we brought on in 2018 and was about 24,000 members that came on, again it started with about $133 medical margin PMPM, that was after a very robust implementation. That individual cohort as we move forward has done tremendously well and progressing to a $168 and all the way through in year four to $193, really starting we're close to that $200 medical margin PMPM. And again, I'll point out that year three was 2020, which was significantly impacted by COVID suppressed utilization. So here is the 2019 cohort. So this cohort represents both the two new markets that came on in 2019 as well as all the same geography growth from the earlier market that came into the – onto the platform in 2019. So it's all the members essentially that came on to our platform in 2019, again starting at a lower medical margin of about $39. But a bigger class of about 35,000 members increasing through year two, which was that COVID impacted year, but then continuing to increase further, very impressively, even beyond that COVID impact still increasing medical margin in year three to $161.

Now, if you look at the 2020 membership cohort. It's interesting because of course, it started in that year that had the COVID suppressed utilization, so it started at a very high rate of $120, but progressed even beyond that to $225 in year two. And now our largest group to date coming on this year, which we expect will be about 52,000 members. Starting at a $51 medical margin, but again, with over 50,000 members, a significant amount of medical margin embedded in that class and that we expect now, as you can see from the rest of the curves to generate over the coming two or three years.

So up to this point, I'd talk quite a bit about our partner markets and how they've been aggressing medical margin. I want to take a second and step back and talk about a couple of things.

First, our non-partner market in Hawaii and then in the second, our direct contracting members. So, Hawaii is interesting. As I said before, it doesn't really benefit broadly from the same alignment that we get in our partnership models. So, you see it in the middle of the page, operating at a lower overall medical margin PMPM with a lot more variability in that number. You can see on the left hand side of the page that we have a very diverse population of members and PCP groups, a large percentage are in our independent and in PO type organizations another chunk that's in health systems. And now for the first time, as we talked about earlier today, our partnership that we've just entered into with the Hawaii Health Network which will represent about 18% of our membership.

With that in place and some other initiatives that we're employing in 2021 and 2022, we do expect to see pretty significant improvement in Hawaii overall medical margin performance going as I said before from above $46 to $57. And one of the thing about Hawaii that's interesting is because of that diversity of our member and provider

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base. It really does also serve as a great laboratory for how we think about operating in our partnership models as we increase the diversity of those models as well.

Direct contracting, still pretty new program. We are literally this month just finishing up the first year of our direct contracting experience. We're still pretty optimistic about the ability -- about direct contracting's ability to contribute positively over time. That's really based on a couple of things. First of all, you see that red circle in the middle of the page. I mean, this has been a largely unmanaged population with very high medical claims expense. And even though you can see that we have overall pretty low medical margin expectations in the first year of about $26 as we have the opportunity to have to really have those numbers on the platform to improve patient outcomes and to increase overall efficiency, we think that direct contracting really can be a positive contributor.

to increase overall efficiency, we think that direct contracting really can be a positive contributor. And one of the other factors in that is when we put direct contracting members on our platform with a partner, we increase our local market scale by about 30% to 70% so we get the benefit of that. And we're also just leveraging the investments that we've already made in MA in those markets so there isn't a huge incremental investment to get these members on the platform and moving in the right direction.

So we talked about our 2021 momentum that we've seen. We already talked at some length now about our 2022 guidance and our confidence in that. We talked earlier today about the accelerated growth in both numbers and diversity that we're going to see in our class of 2023, taking our MA population up to around 390,000 members if you assume as well some nominal incremental growth in DC members getting us to over to around 500,000 members on the platform in 2023 and over 2200 PCPs on the platform.

Now, as we look forward to 2026, there's a couple of different ways or a several different paths we can take to get to this growth and I'm about to talk to. But one way to think about this is even if we take a relatively traditional path to growth, a kind of path that we've seen so far through our – from our inception in 2017 and so let's say something like 50,000 new market members per year over that time period and sticking with that 13% to 15% same geography growth we would get to and by the way, this is largely because the accelerate – because of the accelerated growth in members in 2023. We would get to about 750,000 members in 2026. By the way, as you see from the cohort first, we'd expect to continue to see our membership improve and medical margin notwithstanding the dilution of all these new members coming on. And yet our overall medical expect to continue to see our membership improve in medical margin notwithstanding the dilution of all these new members coming on. And get our overall medical margin PMPM to up around $165 that would drive over $1.4 billion of medical margin and approaching $600 million of adjusted EBITDA, which, by the way, is about 7% of revenue. By the way, all of this assumes that we don't have a significant increase in direct contracting members, I'm still a new program, we'll kind of see how that goes. But we do assume that we're going to see some, of course, continued migration or continued – a maturation of our DC members in terms of medical margin through that time period. But as Veeral talked about earlier, we're not really looking anymore at a traditional growth algorithm. We're kind of thinking about a new dynamic in which we've significantly increased the diversity of our partner organizations.

And significantly therefore increased both the same geography and the new market TAM. If we access that new TAM, it gives us access to a larger base of PCPs of members. Of course, access to more medical margin dollars more, more members will be maturing medical margin dollars over time, even additional leverage on our platform support costs. And again, just assuming that we're going to get the same, the same kind of level of margin maturation across our ACO Reach members that can look like something different, like the right hand side of our of our target page here, potentially growing to as much as 850,000 members.

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Now, interestingly, when we had that additional growth, a lot more members on the platform, a lot newer members diluting it. We probably have a little bit lower medical margin PMPM out in 2026 and maybe close to $150 or $155. But with those extra members that would generate even more medical margin dollars and even more adjusted EBITDA. So a couple of different now paths to growth opened up to us, particularly driven by this new, more diverse class of 2023.

Let me turn for a second to talk about returns, balance sheet Let me turn for a second to talk about returns, balance sheet and cash flow. One of the things I talked about in one of my original slides was we enter markets at scale with existing PCP partners. So that means we're not spending a lot of capital on physical infrastructure enter our a market. We're not spending really any material marketing dollars to attract new members onto our platform. The members are there when we start the platform, when we start the partnership up. Because of that, we have extremely low customer acquisition costs really all of our customer acquisition costs are the cost that we invest in a market or most of our customer acquisition costs are the cost that we invest in a market in that year's year of implementation, when we're ready – when we're readying that market for go live. I think in the past, we've shown a couple of examples of markets and how this has worked on an LTV to CAC basis or a lifetime value to customer acquisition cost basis here what I'm showing you is all the members that we brought on the platform in 2020 and all the new members that we brought on the platform in 2021 on the bottom of the page. The customer acquisition cost for all of those 41,000 new members in 2020 was only about $412 and it was actually under $400 for the 47,000 members who brought in the 2021. If you think about that we're generating you know in excess of probably $800 medical margin per member per year on those new members, which of course we are half of that is going back in into the – into our PCP partnerships. We're maintaining in excess probably of $400 medical margin PM per year. I mean we're essentially getting a one year or better payback on those investments. And one of the things Heidi talked about was the very sticky nature of our members and their PCPs that drive significant lifetime value over the course of their tenure on the platform and leads to lifetime value to the customer acquisition cost ratios of like an extremely impressive 12 to 13 to 1. We have a really strong balance sheet. Okay. We've got over a $1 billion in cash right now. We've only got about $50 million of outstanding debt. We're planning on deploying that capital really in support of the initiatives that you are today. We'll continue to deploy capital to help our physician partners grow. We'll continue to deploy capital to invest in the technology and clinical innovation that you heard my colleagues talk about today. And we'll also deploy capital to add additional capabilities, either through internal investment in Agilon on or when appropriate, through selected M&A. We do expect to generate substantial cash flow in 2022 through 2026, and because of all this, we will not be reliant on external capital to drive our growth.

So before we wrap up, just to go back to the three key takeaways that I hope you walk away from this with, we are maturing medical margins while we're growing members. We're getting that growth through a very leverageable, capital efficient model. And we have high visibility and confidence in our long term EBITDA outlook.

So with that, I think, I'll turn it back over to our CEO, Steve Sell, for a couple of closing comments and then we'll go to Q&A.

Steven J. Sell

Chief Executive Officer & Director, Agilon Health, Inc.

Thanks, Tim. So I thought, I would close with some thoughts on, you know, what you heard today and from my perspective as the CEO, what are really important takeaways and then what will bring up the team and we can do Q&A. So first, you heard from [indiscernible] that Agilon's market opportunity is really inflecting. We see it in our opportunity set in terms of broader new market opportunities in a diversity of partners that we could do that with. And you also heard him talk about a substantial increase in terms of the in-market TAM that is there. Secondly, Ben Shaker and our physician panel on Heidi talked about the compelling advantages in our partnership model.

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You heard our primary care physicians talk about how it had enabled them for the first time to have the total visibility on their practice to truly influence what was happening outside of that primary care office, where there was a transition of care program, our renal program or as Dr. Goggin talked about, going back to the home the way his grandfather did so many years ago. The video that you saw with Gary Grunts is a real example of what that means for patients. Here he is living longer. He's living a better life. He's obviously not going to the hospital. I think we talked about 17 avoided hospital visits as a result of that. And that's all a result of this partnership. I really want to call out what Girish and Dr. Dana Carne talked about, the platform that we are building is very specific. It is intended to support exactly what we talked about around the aligned primary care physician and allowing them to operate at the top of their license and practice medicine the way they were trained to. The fact that we're able to do it at scale, the fact that we're able to pull together all of these different pieces of information and give them that view that they have never had before. They're not going to get that from a payer. They've not been able to have that before. That is an advantage that comes from this platform. Frank talked about Where's Waldo understanding where 20,000 patients in Pittsburgh are at any point in time and if they needed to intervene. Tim and Ben Shaker talked to you about cohort data that gives us increasing confidence in member and PCP economics. And Ben, talked to you about how that's possible. He talked about improving alignment and putting that PCP in a position to do that. He talked about the scale. He showed you a case study of a market that started low and went high, and then Tim showed you one market after another doing that. That's because of alignment and because of scale and because of actionable insights. And finally, Tim just told you, our company is going to be a lot bigger. It's going to be a lot more profitable. And the opportunity for value creation is really massive.

Now, let me tell you what I'm focused on for us to go and pursue that opportunity. I'm focused on three things building the best team you've got in the sense of how we're doing that and just how exceptional these people are in their individual domains, but their exceptional teammates, and we're doing that at every level within our organization and across the country. Secondly, we're really pushing the pace. We are setting the pace on the move to value in new communities and in the communities in which we've got a partnership. And you're seeing physicians vote with their feet. They hear our physicians are winning. They hear how satisfied they are with that. And physicians are starting to recognize that in all types of groups are making that move.

And finally, I'm focused on driving impact, having great implementations, having more stories like Gary Gruntz, and the outcomes that our doctors talked about. If we do those things, we are going to be highly successful and we'll go back to where I started. This is going to be a very big company that's going to have an outsized impact on changing healthcare in the country. So thanks. And with that, we'll we'll go to Q&A.

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QUESTION AND ANSWER SECTION

A

We're over time, so we'll go for 15 minutes or 20 minutes, but we'll have Veeral and Ben and Tim come up and if you've got a question for anybody of the management team, we've got a mic over here and they can...

A

Or the partner.

A

Yeah, or our partner [indiscernible] for that, I see Josh Raskin over there with his hand raised.

Q

[Technical Difficulty]

A

I don't think the mic is working.

Q

[Technical Difficulty]

A

I'll just repeat it just it, Josh for you.

Q

Yeah. [Technical Difficulty]

A

Let me repeat that, so I think, Josh the question was sort of physician acquisition, so we may need to kind of reframe it with our model and then what our acquisition costs were with the question?

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A

You want to talk about how we get here.

A

Yes [indiscernible] yeah. So when you think about our said market geography, we talked about this in the context of the Akron example, 15% same market growth. That's a function of organic growth, our market selection, so more patients choosing Medicare Advantage. That's about 8% to 10%. We're then driving growth incremental to that against the massive total addressable market from a physician and number perspective. That's achieved from a, in a couple of different ways. First, the example you called out which is our partners, to be clear our partners are making acquisitions within the market. They are the most attractive place to access physician risk and can offer the most compelling value proposition to physicians in their community. So that's been a powerful and rapidly evolving source of So that's been a powerful and rapidly evolving source of same market growth. The second way is physicians can affiliate and become part of our network without joining the partner practice. So Kevin talked about seven different physician groups all working part of our Austin network. Those groups remain independent but are accessing the contract structure, the operating infrastructure we've established in the market to be able to go perform and drive the economics in the clinical value out of the model.

A

And Josh I thought I might say something just to clarify. I think it was just the way you asked the question, so you know this, but Agilon is not acquiring physician practices. We're partnering with PCPs and we allow them to grow their practice. So just to be clear, I know you do that, but the question was a little...

A

And the way the efficiency of the growth model and [indiscernible] (03:05:45) comes out of this world from previously is like four $400 per member in terms of what that acquisition is looking like for patients being put on the platform if that's sort of that's a big part of our model the efficiency with which we're able to grow.

A

And Josh, really, that's the power of partnering with existing capacity. If you think about the theme we're playing against, a huge number of PCPs to change our business model and there has to be a solution for existing capacity. They've got patients, they've got history in their community.

A

And we quote that number really just to show how low it is. I mean it's obviously a very low cost considering the lifetime value of what we're going to generate for those over time. So it's a pretty impressive return on health. And I came out of a member's subscription kind of model of – consumer products, good company and it is like this is off the charts obviously positive.

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A

So. All right. Kevin Fischbeck, I saw your hand.

Q

Great. Thanks. Kevin Fishback from BofA. You guys laid out a pretty bullish growth outlook here for the next several years which I generally agree with. It feels actually like probably will be too conservative if anything over the next few years everything's coming together. I see the tipping probably will be too conservative if anything, well next few years, everything is coming together. I see the tipping point you're talking about. My question is really about like your 6 through 10 because it feels to me like this is – you guys laid out why this is so obvious. The physicians have to make this change. Won't everyone have a partner over the next five years? Like, won't you blow away and over the next five years? But then what -what drives the growth in year 6 through 10 I love to hear your answer but also would love to hear maybe one of the physician panelists talk about why a physician might not be ready in the next five years, but will then make that transition in your six or seven?

A

Yeah, I'll start. [indiscernible] maybe you can chime in here, but I think we've really de-risked our growth algorithm based on the entry into these new states. Harold talked about how significant that is once we land in the state, the ability to go to other communities. I think the point I made about getting there first and having the advantage around that is huge. But the point about pushing pace is exactly what you're getting at. There is this tremendous opportunity and we're aggressively going after that. As long as we continue to deliver successful results, we will be successful and our physicians will reflect that and other physicians will join. So I think that's a big part of it.

A

Yeah I mean I think one of the things I get to do with bureaus is go around the country and talk to frontline physicians. And I do think that physicians are going to have to pick a partner of some sort in the next few years. And then it's becoming pretty obvious even health systems are having to figure out the solution. So I do think that's true. I think the longer term part of the business is we think we're earlier than most. We think we're ahead, other physicians are going to have to have a landing place. New residents coming out are going to have to have a landing place. We think primary care is going to grow. We're doing some things going into academic centers and being able to network with rising physicians as to what kind of model they want to practice in. And then I'll just go back to in regards to the economic reality in the type of clinical care that we're delivering. The margins you see today are scratching the surface. There's so much more value. We're not as good at this as we're going to be. So I think between all of those things, I think you're 6 through 10 will look like more growth, potentially from people switching from other teams at that point, you know, there will be different teams out there. And I think that's what I'm seeing. And but I will say in talking to physicians around the country, there is certainly a need to pick a partner and to pick a team very soon. There is an urgency to this, which is why I think we're so focused on pace.

A

The only other thing I'd add is I would think about it as a overall membership opportunity and when we talk about the total addressable market unlocked in the geographies that we're in, 7.5 million members that 7.5 million

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members and we are so early in the lifecycle of launching these partnerships so to the prior question, it really puts our partners in the position to be the aggregators, the conveners of risk in the market and then be the best place to practice because this is the place that you can access full risk on a multi payer basis. And we're so early in accessing that highly fragmented but scaled down stream membership opportunity.

A

And Kevin, two years ago that market TAM was 4 million.

A

4 million.

A

So we've gone from 7.5 million, it's a point about pushing the pace and being first.

Q

Got it.

A

I think we're going to get [indiscernible]

Q

I'm right here.

A

Hey.

Q

Lisa Gill, asking another question. Tim, thank you so much for all the details on 2026. As I look, though, at the membership of 750 to 850, if I listen to you earlier and we think about just organic growth of roughly 15% that tells me that you're anticipating that the growth rate will slow from the 80,000 in 2023. Is that conservative on your side number one? How are we thinking about this? Because everything we're hearing, it feels like the numbers are going to continue to accelerate would be my first question.

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A

I think that was the point between the two sides are trying to make, which I think even if you take that work that you would call a traditional way that we've grown so you can get to 750...

Q

Right.

A

...from our 2023 membership by saying we'll add 50,000...

Q

Yeah.

A

...new member markets a year and do 13% to 15% growth, you know, 50-odd plus or minus and plus or minus 15% growth. You're going to get to that number. And the big opportunity for us is especially now that we've seen in the class of 2023 and that tremendously increased diversity which drove that same geography. But you're right, that same geography tam from four million members to 7.5 million members. Obviously, that opens us up to a bigger growth number. And so that's why we kind of kind of raised it and said, we have a high confidence, certainly in 750,000, because we think we can get there the way we've been getting there, but we have an opportunity to do more with this new diverse opportunity, I guess that's out there.

Q

Okay. Conservative. The second part of my question – the second part of my question really is for you, Steve.

A

Yeah.

Q

As we think about these capitated models and we think about it from the managed care side, right. More competition in the marketplace, what's your confidence over time that the current rates as they stand today, that the level of capitation that you receive at Agilon stays number one and number two, you know how you see that shifting amongst players over time. So we hear a lot in the marketplace around up coding and other things, right.

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A

Yeah.

Q

And so just any views that you have about the future of these kinds of programs?

A

Yeah. I mean, I think we're very comfortable in terms of the unit revenue progression. You're talking we're at about 85% of premium today. We've got these six national partnerships that we talk about and then the locals. I think the value that we're providing to these payers and Heidi really hit that pretty clearly is so great that we feel very confident that – that is going to continue and our early experience in terms of those renewals, in some cases, it actually steps up. In some cases it stays at the same place. Payers are going to need to have far more senior patients in these types of models. And right now, we are the vehicle for them. In so many of these communities that once were there were there. So I think we feel incredibly comfortable around that.

A

I would just say, from a payer perspective, that's probably been the biggest evolution. You think about four years ago when we started the company trying to go get a full risk contract. Now we're working with national payers, you know, across the board, as Heidi talked about, but that had bespoke provider relationships in these geographies. They view us as the way to organize that geography and then to be able to take risk at scale, which as Heidi talked about brings tremendous value. They get outsized membership growth, that's de-risked from a profitability perspective with high confidence around quality.

Q

And what about the scrutiny, though on risk scoring in the marketplace? Do you think that that has an impact on the future overall premium?

A

So I think there may be changes in terms of what's allowed from a process perspective. But I think our out year forecast is very modest in terms of the improvement that we see from risk adjustment. We want to share sort of the context.

A

Yeah, I mean, I think just to get kind of a fulsome snapshot because we get asked it all the time. I mean, most of the benefit that we get from improvers and just are more accurate, risk adjustment happens really early in the lifecycle of these markets. In fact, a lot of it happens through our building up compliance with a high level of those

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annual wellness, physical, structured annual wellness visits during even the implementation year. So if you go back and then as we move forward, obviously more and more of our medical margin improvement comes from you know impacting the rest of it, not just from risk adjustment improvement. So just maybe an interesting data point is if you look at our three most mature markets, so those three markets that were implemented in 2018 and 2019 Columbus, Akron, Austin, they – and look at their performance from risk adjustment for 2019 to 2021s are kind of skip over the COVID impacted year. But over that two-year period, our – the – our impact revenue from just improve risk adjustment when that time was less than 1.5% in each of those years for those markets. And I think our actual total average RAPH scores for those markets is like I don't think it's meaningfully over a 1. So we're not, you know, we're not like pushing the envelope on our risk adjustment scores. And I think that plays into the question around you know is there's more scrutiny on a how does that apply to us?

A

So I think the takeaway is we're not relying heavily on RAPH in terms of what we've shown you from a margin perspective. And I think there are changes within it's going to drive more patients into models like ours. And I think we're doing it the right way it's a physician peer reviewed process that we have.

Q

Okay. Great. Thanks.

A

Okay. Why don't we want to go to Jefferies team in the back.

Q

Yeah. Thanks. This is Jack Slevin from Jefferies. I'm not sure if this is true [indiscernible] . It's probably don't tell us off Kevin's question nicely, but the anecdote around ESRD your kidney care I think was particularly interesting.

A

Yeah.

Q

It's one of the probably the area outside of primary care where we're seeing the most innovation in terms of diabetes care and all the risk taking. Do you think with your flexible model that direct partnership with [indiscernible] is something we can consider it – consider or do you think it was a symbiotic relationship I think I've heard them say that before third-party partner they're using it?

A

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Let me repeat it for the webcast, but the question is about our strategy around end stage renal disease so around [indiscernible] 03:16:41 disease

A

Yeah, Jack. It's, it's a big area for us. We do have a partner that we are working with across a series of markets. We believe it's a significant opportunity from a cost and quality experience. And we'll start maybe five or six markets and we'll rapidly expand out with that but that's how we are looking but the idea in that is that it constantly comes back to that primary care physician. They've got that information back and thinking about in-home care teams as an extension of that primary care physician, so it all goes back to that patient-physician relationship.

A

Yeah. And I think, I think the other thing I would add too is given the scale that we have in these geographies, I mean just over the course of the last two weeks, we've had multiple meetings with, what's typically the large nephrology group in these geographies and so they are very tuned in, in terms of what's happening and what our primary care physicians are doing, just given the magnitude of senior patients that we're managing.

A

Now, we're going to George Hill over here.

Q

Thanks, guys. I'm going to pull some of the 2026 numbers apart and ask you to comment on them. I thought it was interesting, as you guys have framed the numbers, the variance decreases as you go down, what I would call the KPIs as opposed to increases as you go down the KPIs. So, there's a 13% variance in the expectation for lives and 7% on med margin and then like 3% or 4%, 5% when you get down to the adjusted EBITDA. So, I guess I'd ask you to talk about kind of the interplay of the numbers and how you think about that. I'm actually surprised the EBITDA expectation for 2026 is so narrow the range. So, I guess just, I'd love to kind of, if you could kind of walk through the build, how you, how you think about that, how you get there? And what are the big factors that push it to one end of the other?

A

Yeah. That's kind of interesting. So, I'm going to go back and take a look at that. Now, that you've quoted it that way but I think the flow through of the numbers is pretty I think the flow through of the numbers is pretty. You'll find it's pretty consistent. If you think about the really big factor that drives it is how much are you maturing the medical margin on those underlying cohorts? And I don't know if that's what's driving that, compression as you come down through it. But then when you get down to the bottom, it's the platform support costs are kind of the platform support costs. So you're, you're going to get leverage out of those one way or another. But I think probably what's driving the number that you're talking about is this factor of, how are we actually looking at new members when they come in and how they either dilute or develop over time? And so but you're right, it is a pretty tight range when we look at that to understand what that impact is of, say, the incremental members. If we went from $750 to $850, really only has about a $10 impact on medical margin PMPM through dilution. But that's

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interesting that you put it that way. So I'll – I'll go back and look at it. But I think it's probably everything in the P&L is very largely a factor of how those medical margin dollars progressed under underneath that number. So, yeah.

A

Why don't we take one more question just because we've we've gone over time, but if anyone wanted to pose a final question, we can cut it there. But I think seeing their questions, I think we've answered or okay, how about in the back here in the middle?

Q

Thanks. Can we just go back to [indiscernible] 03:20:00 REACH for a second and just maybe spike out any major differences there that we should be mindful of versus DCE? And then secondly, Tim, you mentioned just given the balance sheet, some M&A optionality, maybe talk a little bit about what that could look like over time.

A

Yeah, so REACH, it goes live in 2023 and still getting information on that. But but a high level, it increases the focus on equity and on access and improving community health. And so we believe based on the communities that we serve and our conversations with the innovation center, it lines up very well with our mission and and our conversations with the innovation center, it lines up very well with our mission and that that we will benefit from that. There are some changes in terms of things like quality withholds and some others that the existing participants asked for changes around which are positive and effect, some of the out-year economics in that program. But the innovation centers committed, they want more participants in that program, and we believe there's the opportunity to expand it to other countries.

A

Yeah, on the M&A question let me start and Veeral you might have a comment to make on this too. First of all, just going back to an earlier question, we're definitely not talking about when we speak about M&A, acquiring obviously physician groups or anything. That's not that's not obviously our model. And right now, we certainly don't have any major M&A, anything in the pipeline that we're getting ready to announce or anything like that. So with that as kind of background, if there are opportunities where we can acquire a capability, acquire, an organization that has a capability that will help us deliver on a lot of those clinical programs that we were talking about during the day, then that's something that would definitely be interesting to us and that we would be – that we would look at and think about. Like I said, we don't have anything major kind of in the pipeline right now to talk about, but we would, we're constantly looking at those and we're very open to those and, anything that we can use any way that we can use our capital, deploy our capital to support those objectives, particularly in advancing those clinical programs would be, of great interest to us. So and Veeral if you want to jump in.

A

Yeah. No. I think you said it well. Platform acceleration from a capability perspective, enabling what we're doing from a data and technology perspective, from a clinical perspective to go attack medical margin based off our scaled membership base would be primary focus. And then I think selectively we will evaluate where can capital

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be deployed in a way that's congruent with our growth strategy. But I wouldn't say that's a principal focus. I think it's disproportionately around platform and platform capability.

Unverified Participant

All right. Before I conclude it here, we really appreciate it. But before I handed over to Steve just to say a quick thank you. I want to let you know we'll be hanging around in the hallway afterward for 20 or 30 minutes if you want to catch up. Steve, any kind of last closing remarks for you?

Unverified Participant

No, I would just say we're really excited about where we're at and we see a tremendous opportunity going forward and we're making a real life, real difference in patients' lives and for our part physicians in their communities. So, thanks, everybody. We'll be around to talk to you. Thanks.

Unverified Participant

Thank you.

Unverified Participant

Thank you.

Unverified Participant

Thanks.

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