06-Sep-2023

Agilon Health, Inc. (AGL)

Wells Fargo Healthcare Conference

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MANAGEMENT DISCUSSION SECTION

Stephen Baxter
Analyst, Wells Fargo Securities LLC

Okay. Good morning, everyone. I'm Steve Baxter, the healthcare services analyst here at Wells Fargo. We are pleased to be joined by Agilon Health, a leading player in the physician enablement and value based care space. From the company, we are joined by Tim Bensley, CFO; Ben Kornitzer, Chief Medical Officer; and Matthew Gillmor from Investor Relations. Thank you very much for being here today.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

Thank you.

QUESTION AND ANSWER SECTION

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Yeah. So just to start on the top. Obviously, utilization has been a huge area of focus. On the second quarter call, you guys called out some really strong performance in terms of the clinical model driving, like lower inpatient type utilization, compensating for some of the things you're seeing on the outpatient and ER side. And that's like the kind of trend the company drives to over time. I guess what's the latest update you can provide on what you're seeing on utilization front? And then we'll talk more about the clinical model.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. I think you nailed it, though, by the way. Obviously, there has been a lot of focus on utilization coming through the first half of the year. And I think this current environment really gives us the opportunity to demonstrate the power of the Agilon model. I know that sounds like it's simple, but our model is essentially designed to have a more efficient and really more consistent impact on utilization than probably just any other model out there, just certainly the normal fee-for-service environment. If you think about it, we're coming in with this overall partnership model that drive this tremendous alignment with the primary care physicians that we partner with to really work on driving outcome over time. But the second thing is we're bringing this platform that allows the – or helps the primary care physician both identify and bring the right care to their patients that then essentially over time, does have that kind of leveling impact on utilization and also helps us drive utilization down below what the overall I think [indiscernible] (02:10). I mean, essentially at the end of the day, I think an attributed – a PCP that's operating with an attributed patient and that full kind of risk model is approaching that patient in a much different way. We are – our physicians are essentially providing tremendously improved continuity of care versus what you would get in fee-for-service and a fee-for-service model utilization is managed by somebody gets sick and is very ad hoc. They have to go into an emergency room or potentially get hospitalized, but it's all done in a very ad hoc basis where we have much better continuity of care. We're handling the conditions of our patients on a more ongoing basis and basically manage them on a proactive basis as they happen. I think that has the impact of both lowering utilization as well as having more consistent utilization over time. And may even have a positive impact on avoiding some of the pent up demand issues that came out of post COVID. Having said that, you can see the results in our numbers, though. We came out and talked about Q2. We said that we're not only seeing that we're beating kind of the average utilization on the inpatient side. And by the way, of course, inpatient is by far the largest part of our cost basis. We're actually seeing an actual single digit decrease in inpatient utilization against our population that we reported in Q2. Now, at the same time, of course, we have been seeing pretty large increases in outpatient. That's a smaller portion of the overall cost pie. And so the inpatient decreases more than offsetting that. But we've been seeing that phenomena. We've been talking about it over the last year or not over the last couple of months. Having said that, of course, the big payers get information more current than us.

And so we want to make sure that we're being kind of thoughtful about what they're saying. And so we did, of course, have strengthened our reserves both in Q2 and for the outlook for the balance of year to make sure that we're covering any potential increase in utilization and can avoid – make sure we're properly reserved as we end the year.

Ben, I don't know if you want to talk anymore about the impact of the model on – is that kind of leveling of utilization and improvement or...

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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By the way, Tim has been doing such a good job at our meetings covering the clinical component [indiscernible] (04:28) I'll take all the financial questions and he'll take all the clinical questions. If you think about – I mean, the vast majority of admissions to hospital are ambulatory sensitive. So those are patients with heart failure, can you do a better job managing their heart failure so that they're on the right medications, they're taking daily weights or blood pressure control. We published a white paper showing the impact of better diabetes control. Those patients were 50% less likely to get readmitted if their blood sugars were well controlled. We have a program that really focuses on our most seriously ill patients. We're seeing statistically significant decreases in terms of admissions when we're focusing on those patients, ICU stays, ER visits, total cost of care and then also more days at home, which for our most seriously ill patients is really what they want to be doing. And if you think about it, it's all about having that longitudinal continuous relationship with the patient to avoid those exacerbations. But it also does, if you think about it, if a patient has lower back pain, instead of taking a look at a billboard that says, call the laser spine, they're going to go see their PCP. The PCP is more likely to say, listen, let's see how you do with physical therapy, let's see how you do with some conservative management. And so our ability to do that over time really mitigates against a lot of those spikes that you would see, but also give us the opportunity to lower the cost of care.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. I mean, it just makes sense if you're seeing especially your most critical patients with the most conditions on a more regular basis, you're just proactively managing their condition, which is going to avoid a lot of utilization. And because you're seeing them more consistently have this more just better continuity of care, you're able to actually get them enrolled and take advantage of these programs that we – these clinical programs we've put in place. So I mean, our entire model, the power of our model is really built around that concept. And I think it's having a positive impact. And it's one of the reasons why we can have differential utilization performance and differential financial performance than probably the broader fee-for-service environment.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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And then Ben, there are programs that are more centrally driven by Agilon, whether it's things like renal or palliative, like high risk patients versus things that are managed more kind of in like the local markets. Can you talk a little bit about why these programs are managed more at the Agilon level and then how you cascade that down into the markets?

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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Yeah. So historically, if you think about the way of PCP practices, PCPs tend to be very, very good at taking care of patients that they're seeing at the moment. Where they have blind spot is all those patients who aren't coming [ph] to the office (06:52) that day. And so if you see 20 or 30 patients a day, you may have 2,000 patients on your panel that you're not seeing. Knowing which one of those patients are at risk for heart failure, knowing which one of those patients may crash in dialysis, knowing which ones of those patients may have anxiety or behavioral health issues or social determinant issues that are preventing them to come in to see you in the first place. So our ability to aggregate really large amounts of data from all of these different payer plans from traditional Medicare through our ACO REACH relationship, allows us to basically create benchmarks and algorithms to identify who's at risk. No individual PCP would be able to do that. In fact, even our most sophisticated practices wouldn't be able to do that. So we're able to do is bring them this information of which patients are at risk, [indiscernible] (07:36)

resources in those practices that can get those patients on that physician's schedule. And then rather than having a sort of disconnected, siloed approach, this Humana patient, this United patient, this is the fee-for-service patient. We can present them with a singular view of their patient at the point of care. And if you're seeing [ph] Betty Smith (07:55), all of a sudden you realize Betty Smith needs to have her medications adjusted for heart failure. So double her dose of LASIX. She has gaps that need to be closed. She hasn't had a mammography done this year. And she's seeing four specialists, you should coordinate care better with those. So the fact that we can bring that information to the position at the point of care measure what that physician is doing so that we're able to give them feedback and then help them understand proactively, well, based on Betty's risk factors, this is someone that you've only been seeing twice a year. You probably want to see her four times. You're at six times here. And so the structured standardized way to do that, that's very, very intentional. That's actionable, that can be measured and tracked over time. That's the capability that we bring that's delightful for the PCPs, but also make sure that you have really high levels of performance consistently across our partnerships.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Now, the segue to that, I guess, be – like, you guys obviously have great capabilities and access to data here, like payers have some of these capabilities as well. I guess how different are the solutions you're putting out and how it flows through to the PCP and ultimately the patient versus what payers are enabled to do on their own?

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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Yeah. I mean, first of all, we work very close with our payer partners. I think what's distinctive is our relationship with those PCPs where we have immediate proximity. So if you think about the example I gave, we're not just identifying those patients. And there's a benefit to being able to identify them across multiple payers, right? So that we have visibility. I would think the average market may have five to seven different MA contracts, as well as a traditional fee-for-service [indiscernible] (09:30). So that multi payer data gives us sort of granularity, because each one is slightly different. But then the fact that we actually have resources in that practice, whether they're nurses, whether they're operators, whether they're social workers or pharmacists, is a major differentiator. And then we can work directly at the point of care, whether it's through the EMR or through other point of care tools. So that when that PCP is seeing that patient, we're actually able to [indiscernible] (09:55) information. It's a – one of the frustrations, as the physician has always been, you get different information from different payers. There is no way to keep track of all the different contracts and permutations of a contract. But when you have a singular view for every single patient over the age of 65 – and there's commonality, because we know. As you get older, your kidneys slow down, your heart doesn't pump as well as it used to. Unfortunately, your brain doesn't function as well as it used to when you were younger. So that commonality allows us to deploy solutions across that population.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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I think the comment you made about proximity is important as well, because the other differences – and I think obviously, the payers have been out there doing this a long time. And obviously, they're – they can be successful to the extent that they can with the programs are in place. But the difference between that and a program you're putting in place that is being delivered to the patient through their PCP versus getting a call that, hey, this is your health insurer, is I think a big difference as well. And so I think that the opportunity or the probability of success of getting somebody to one of these clinical programs and staying in it and working through it when their PCP is leading them through it is a big difference.

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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We see for our highest risk programs, when we had external groups making phone calls to talk to patients about enrolling, we had about a 20% opt in from the patients. When we had the physicians having those same conversations, it was 80% to 90%. So that credibility is extremely high. I also think that there's something very satisfying to the PCPs about being in the driver's seat and seeing that singular view. And so with one of our early partners that had worked with a bunch of different payers. Those payers had given fax or recommendations on what to do as patients came in. And there were two physicians we spoke to at a competition who could take those faxes, stack them on their desk to get the highest level without actually responding to a single one, because they thought they were so low value. Now, that's embedded in their EMR and this becomes part of how they actually operate. They're delighted and the recommendations that they're getting don't feel like they're coming from a disconnected third party. But they say these are actually our peers. These are the people that we work with. These are people who are core to our team. And so those recommendations that they're seeing actually make sense to them and work with their workflows.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Yeah. So when you think about getting a new partner coming into that environment and having this new access to information and then some reengineering of how they actually provide care, I mean, take us through how that works. Like, how do you implement that and how does it progress over the next couple of years as you work to drive, I guess, greater adoption of the tools that you make available to them and greater standardization maybe across the various physicians in a practice?

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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Yeah. So I think the focus of the greatest credibility in our model are the physicians themselves. So we bring colleagues from other markets. We've done this before. It's almost like, say, here are the answers to the test. But we're going to tell it to you on day one. And then working with what are really already highly effective organization and the groups that partner with us are successful practices within a fee-for-service construct. So they have governance, they have good leadership. Our ability to sort of reorganize in a way that supports them to value based care is very transformational. So one of the things that we often do is help them create [ph] pods (13:12) rather than working across 50 or 100 or 200 PCPs, basically shrinking down levels of accountability to 5 to 10 physicians. There's often a pod leader, so that's one physician who's within that practice, knows the doctors, they admit to the same hospitals, they refer to the same specialist. And so that person becomes the champion for these programs. We had a retreat last year where we had one of the physicians who was essentially the pod leader for all of the pod leaders. And what's so interesting for him is that information that we brought at the point of care, he got it and he disagreed with us. And then he took a look at his own chart and he realized that one of his patients had a pulmonary condition that he had missed. And he said that to the whole group. And it changed the whole way that they looked at the process, because all of a sudden, rather than this just being another box to check, they realized that this resulted in better patient outcomes. So when they heard that from one of their peers who was respected within that practice, the amount of influence, amount of credibility that brings is very, very powerful.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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And then I guess it'd be interesting to get some perspective on how much the implementation process has changed over the past few years. Have you started to become more familiar with the company? The company

has obviously deployed some capital into areas that are helped with that, like your sales cycle is getting pulled greater forwards. Have you put more time on the platform before you go live? I guess, how would you contrast how the implementation process works now versus maybe how it worked a couple of years ago?

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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One of them is clearly the fact that our business development process has been accelerated and we are definitely getting longer implementation. The longer you can get, the better. Even for things like just getting the good BOI process in place, getting the good – getting risk adjusted properly in the first year. And doesn't just get you to the right – revenue right in the first year when you go live, but it also just allows you to get that course of care kind of in place and ready to go for the first year. The second thing is we are now actually – and you can probably talk a lot about this spend. We are starting to – now, I'm already implementing some of the clinical – that it is allowing us to start to implement some of the clinical programs and get them ready to go in year zero. So we have partners in year one that are already implementing some of these more sophisticated clinical programs that probably in the past, they wouldn't be entering into in year two or year three. And so that's tremendously helpful in getting kind of people up the curve faster. And the last thing that we're just now getting going on that's going to be really helpful is, we just invested and there may be more, you can add more if you want. But I was going to throw in, we just acquired this company, mphrX, which has this [indiscernible] (15:42) product that allows us to get much quicker integration with the EMRs, which just gets more information back to us, which allows us to drive those programs even more efficiently and in a better way. That is so important, because we're entering into so many more partnerships that are multple – in multiple EMR kind of these distributed networks. So if you look at a place like very, very large group we brought in Detroit, United Physicians. I don't – the number of EMR combinations and [ph] instances (16:14), there is many more than there are actually EMR providers, because they're all on different [ph] instances (16:17) of the different EMRs. And it's just really allowed us to getting that ability to do that really quickly and get that information up and running, because it gives us the ability to drive the market forward quicker as well.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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And then when you look at – obviously, there's a lot of focus in the past couple of years on MaineHealth as your first hospital partnership. Give us an update there on how that's going and I guess how we're thinking about the broader population of opportunities, so within health systems?

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah, absolutely. I mean, first of all, the overall performance of – we have a very big, very diverse class of 2023 that came on. It's over 100,000 members. The good news about the class of 2023, which includes MaineHealth is that it is actually bigger than we thought it was going to be. So we were a little conservative with people like MaineHealth coming in, of how well we were able to pull through all the attributed members, get all the payer contracts in place the way that we wanted to, and that has worked out better than we expected. And in fact, our membership in MaineHealth by itself is quite a bit larger than we expected to be, which is great. It's a little bit of a different model obviously and that primarily, it's employed physicians.

There are some affiliated physician groups as well, but it's in primarily employed physicians. So the way that you approach that is something that we had to learn and how you actually go in and work with the medical group to incent the physicians to do the things that in our other partnerships, they're getting impacted by the fact that they're getting 50% of the surplus back to them. But it's a really – MaineHealth, it turns out, and particularly the

medical group of MaineHealth is a group that has historically been kind of pretty committed to high performance. And I think they see this as many opportunities. One is to just provide better care for their patients, which is a big motivator by itself. It's an opportunity for them to really economically sustain that primary care physician medical group, which is continues to be a big motivator for them. And it's a way for them basically to also avoid unnecessary utilization of the rest of their system that allows them to kind of get the right patient in the right environment and the rest of their system without having to invest incremental capital to do that. So all that, I think, has been aligning that group to really perform very well for us. And so far this year, the group is performing in terms of – on a medical margin PMPM basis, right at or actually slightly better than we expected when we entered the year. So we're pretty encouraged by it. We're taking, of course, those learnings and can immediately apply them to the two big regional health systems that we're implementing in [indiscernible] (18:53). So that's been helpful. Now those groups interestingly get double benefit, because we're getting the benefit of learning from what we're doing with MaineHealth, but they're also getting the benefit of both entering markets where we already had PCP group partners.

And so there's already infrastructure contract. Everything was already set up there. So they're – they kind of got a jump start to begin with plus the fact that they're getting the learnings. So I think the implementation process for both [ph] Premier and Holland (19:20) is actually going really well. And it's really encouraging that that's going to give us – I guess, if you think about the way that we built the original network was we started with one partner group in Ohio. And as we built success, we built more and more on that success. And our success became evident. That became a big recruiting tool for [indiscernible] (19:40) groups. And we're just at the very early stage of that for health systems, but so far, so good. Maine performing well, implementation going well in these two new markets. So we're pretty optimistic and certainly expect that health systems will be a part of every one of our classes going forward. I mean, we don't have anything specific to announce for 2025, but I would expect that health systems will be part of the mix going forward.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Okay. And then it's good to hear on the second quarter call, you're already signing partners for 2025, I mean...

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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We are.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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...you got to pull forward a little bit of the sales cycle. I guess as we think about it, I'm guessing you're not going to tell me the size of the 2025 class today. But when we think about it conceptually, I guess, how should we think about whether there are or not any kind of rate limiting factors around like what the size of a class could be or comfort level on board in a certain level of membership, things like that?

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. There really is nothing limiting it other than our understanding with the partner that they're kind of ready to go. So it's worked out pretty naturally that we've grown up now. That for a couple of years in a row, we're going to have classes that are in excess of 100,000. So we don't quite need to be quite that high to get to the number that we put out there for 2026. So hopefully, we're being a little bit conservative in that. But certainly, there's nothing that's going to keep us in the class of 2025 and 2026, on top of these very big classes in 2023 and 2024 to get to

that 850,000 [ph] MA members (21:08) or something like – I mean, there is nothing there. If we have a couple of big groups that are available to come in and for whatever reason, one of those classes could be bigger than what we've done. There's nothing keeping us from doing that. And particularly, if it's bigger because we're bringing in a couple of very large players like – this year, we brought in two pretty big groups with MaineHealth and United Physicians. One health system, one kind of distributed [ph] PO (21:33) kind of network. If we're bringing in – if for some reason there was a couple of very large ones to bring in and that pushes the number higher, there's no like membership limit on what we can bring in each year.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Okay. And can you guys talk a little about your success recruiting physicians into existing practices, that's been another lever of growth, like participated in the success that your physicians are having in the market. I guess how have those trends worked over the past couple of years? And it's been a pretty tight labor environment. Has that impacted the ability to recruit physicians at all in the practice?

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Well, maybe – there's two different ways to talk about this. One is the role that we have when we go in and establish an anchor partner in a market as sort of a consolidator within that market. So that's a little bit different than what you're asking, I think. And we've been obviously pretty successful there. So about a third of our – what we call same geography growth, which has been kind of low to mid single digit in our partner groups over the last few years, about a third of that is really coming from that just consolidating other physician groups essentially into that existing group. Supporting the rest of the growth, which could require obviously the ability to recruit physicians into the existing partner is – obviously, it's a challenging environment to do it, but I think we've been pretty successful there too. But two things are helping us, and I'll let Ben talk about this. But one is, to begin with, we have very low physician turnover in our group, so that's helpful. So you don't have as many holes to fill. And then, we've had a number of programs that we partner with our physician groups with to help them recruit new physicians in. I don't know if you want to talk about our ability to kind of do that side of it separate from the kind of consolidator function.

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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Yeah. No, I mean, we work very closely with our partners, as Tim mentioned. Our physician retention is in the, I think 95% range, which is very, very high nationally. And then we offer the ability to help them go and – primary care physicians either getting that new [indiscernible] (23:31) or they're moving into the geography, as well as physicians who have their own practices and want to transition and join an existing Agilon [indiscernible] (23:40) may be a one or two physician practice. You want to join one of the larger aggregating practices that we have. We've helped facilitate identify that, create the economics to do that. As I talk to a lot of these physician groups, one of the concerns of that is the sustainability of primary care.

I speak to more physicians and one of them is a third generation doc who said that he was pretty pessimistic a few years ago about the future of primary care, would have told his kids, don't go into medicine, definitely don't go into primary care. He's now recruiting actively into his practice. That hadn't happened before. There's a level of optimism that just didn't exist before. And I think it's a combination of one that economics have really flipped, right? Going through primary care, that can be a very, very attractive economic opportunity, but they're also enjoying the practice more. They're feeling a greater sense of ownership. Their patients are having better outcomes. And actually, some of our most successful physicians are doing it not by running faster on the hamster

wheel, but by seeing less visits per day, but [indiscernible] (24:39) focusing on the sicker patients. And so they're really enjoying that. And when they speak to colleagues, that's very attractive.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Okay. Then pivot a little bit to the ACO REACH side. I think that was like a positive surprise in the second quarter's results that was running so well. And then also, that you were increasing your outlook for the year there. Could you just help us understand a little bit the kind of the moving parts, like what gave you the visibility that your performance was better than maybe you initially expected and how you expect that plays out both the balance of this year? And then as we think about the sustainability of that performance, as we think about the next couple of years and getting out to your guidance.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. No. Absolutely. So yeah, we're really – we're in kind of a watershed year for ACO REACH for us after. It's been a pretty volatile program for the first couple of years. So as you mentioned, it's really interesting where we came out in Q2 and said, hey, look, based on everything that's going on in the current environment, we're going to be a little bit more conservative with the MA side of it. We actually lowered our MA medical margin net by about $30 million and really offset that by taking our ACO REACH up. The combination of those two changes, the sort of more conservative viewpoint on MA and a really increased confidence, which I'll answer your question here in a second around ACO REACH, really gives us a huge amount of confidence in the guidance that we put out there. So we're pretty confident with that kind of new mix that – we're confident in the guidance that we put out for – at Q2 for 2023. So as you said, a big part of that is ACO REACH. So why are we confident in that? Well, a couple of things. First of all, the big volatility in ACO REACH over the last couple of years has been around, what's your revenue number going to be. So we get really good visibility from CMS on our own numbers in terms of what our [ph] rep (26:24) performance is going to be and what our cost performance is. But this – what the overall at the end of the day benchmark revenue rate's going to be, which just moves with cost during the year or in other words, predicting what the retro trend adjustment is going to be has really been a big problem.

So the first thing that happened to us was around the end of the third quarter, beginning of the fourth quarter last year, CMS really did start providing significantly better information to all of the participants around what the overall Medicare fee-for-service reference population looks like, which allows us to calculate what we think the RTA is going to be. And so that gave us a more complete view of revenue. So right now, well into the year, we feel like we have a really good viewpoint on what that RTA is going to be. We obviously have a good viewpoint on what our risk adjustment numbers are going to be.

So we have good confidence in our revenue number. But the more important thing that's happening is and maybe we didn't quite get this when we started the year, was when you're in a year of sort of a little bit higher utilization, our model is, of course, as we talked about in the very opening question, designed to outperform that utilization trend. We are seeing that significantly more clearly in ACO REACH, because we have the ability to compare our performance back to that Medicare fee-for-service population data that they give us and our costs are actually – or our utilization is actually outperforming that reference population by like over 300 basis points. So you can – and now, that's not surprising because you're comparing it to a much more unmanaged fee-for-service population. But it's really encouraging for us to see that the impact of our platform and our processes, our programs, our clinical programs on that ACO REACH population is really having a dramatic impact on cost. So now for this year, we're seeing much more confidence around the visibility to revenue, really, really good spread between our performance and the fee-for-service population. That's driving outsized performance overall. As you go into the future years, the interesting about ACO REACH is the revenue number will just move with whatever the cost trend

is. So as long as as you go forward into the future, you can perform on a cost basis at least as well as the reference population, you kind of will maintain that kind of $30 million build up that we've got in profitability. And of course, that's not going to happen. So as we go forward, we will – clearly, our model is set to outperform the reference population. So we would expect that as we move forward through 2024, 2025 and 2026, that our profitability in ACO REACH will actually expand below the $30 million to $35 million we're forecasting this year. And then the second thing is we took kind of a one-year hiatus on adding new members.

And a lot of that was because there was a lot of uncertainty and volatility in the program. And it wasn't something that people wanted to jump into. We're now jumping back in next year with a couple of new partners and we'll be adding about 25,000 new members as well. So we get the benefit next year through 2026 of both actually able to now grow the membership again and really feel much more comfortable at how our model works in the context of ACO REACH. So that in context with, what we've said about how we're going to now end the year on MA, we've got a lot of confidence in delivering this year's guidance and all that actually help us out going into 2024 as well.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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Yeah. As you think about like what the size of the business could evolve to beyond 2024, like I imagine that you have as many Medicare fee-for-service patients as you do as MA patients in your panels or something about that if national penetration's 50%.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. That's probably about right. Yeah.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

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In theory, you could have, in ACO REACH book, that's as large as your MA book over time? How do you guys think about that, given that it is still a newer program, like what's the right size for that?

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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I think what – I think the answer to that question will come more when we understand what the next generation of ACO REACH is. So right now, the program is, it's CMMI innovation program and it's scheduled to sunset at the end of 2026. CMS has obviously come out and been very vocal about that they want all of Medicare patients in some kind of a value relationship going forward. So the expectation – and by the way, I think it's also been clear that when you put patients into a value scenario, the ones that perform best are the ones that are in a full risk scenario. So we would – as ACO REACH is, so we would expect that there would be some kind of a next generation of full risk opportunity for fee-for-service patients that's going to move on beyond the end of ACO REACH.

I think when that gets announced, that'll be the key input to the answer to your question of how many more of our current partners have fee-for-service members that they're perhaps are participating in some other ACO program or something that would then basically be brought under the Agilon umbrella under a full risk scenario. So I mean, ultimately, yeah, at the end of the day, I mean, it would be nice to have 100% of our Medicare members in our – 100% of the Medicare panels and our partners being on a program. But I think we're going to have to see – obviously, ACO REACH got off to an interesting volatile start. We're going to have to see what the next generation is to see how that really plays out.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

Q

And then a big focus, obviously, for next couple of years is going to the transition to the new risk model. Just give us a sense of as you guys have analyzed the risk model transition, I guess what you see is the impact to the company initially and then what you're working towards to offset whatever those impacts are.

Timothy S. Bensley
Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

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Yeah. So let me give you about a minute and a half answer and then maybe you have a couple of interesting thoughts on this to make sure we don't run out of time. But overall, when we've looked at the impact of it, we're in a little bit different environment than people that are in like super high risk adjustment level. Our risk adjustment – average risk adjustment is much lower than most. We have a pretty broad population out there. Our average risk adjustment – our average RAF scores are like just a little bit over 1 when we've looked at the impact of it. And now, we've got a pretty good view, right? Because all of the impact of the model on our risk scores is, we're two thirds of the year doing the really good work that's going to get us to how we get paid next year. We believe that the impact of the transition to [indiscernible] (32:51) by itself, the really good work that we continue to do on risk adjustment with our members. And when you put that, in fact, in combination with the actual benchmark increases coming in next year, the mix of members that were coming in, all that combined, we feel like our overall revenue number next year with all this in should be somewhere in the flat to slightly up on a PMPM basis.

That's good news for us. You put in combination with that, all the great work that we're doing around clinical programs and actually getting more confidence in our ability to beat that fee-for-service population in terms of utilization and drive costs out. It gives us a lot of comp and that – and the third thing is we have a really strong class coming in, because it's going to start at a higher than average medical margin. We feel really, really good that we're in a good shape rolling into 2024. Look, yeah, and into 2023 [indiscernible] (33:48)

Benjamin Kornitzer
Chief Medical & Quality Officer, Agilon Health, Inc.

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Yeah. You know what I would say is, when you take a look at the changes in [ph] V28 (33:52), a lot of them are really directed on what I would call very aggressive practices. Our physicians tend to practice in the traditional primary care model. We're seeing commercial patients. We're seeing Medicare patients. It's not a purpose built clinic. So we're not screening every single patient with an echo to see if they have signs of heart failure. We're not doing CT scans to see if there's any atherosclerosis of the aorta. We're not regularly diagnosing protein-calorie malnutrition. All these diagnoses which aren't sort of bread and butter medicine. We practice traditional bread and butter medicine. We do a really good job identifying the appropriate diagnoses, largely to connect them with the right programs, to make sure that if we have a renal patient, that patient is being hooked up with a team, they can monitor their medications, they can control their blood pressure, they can give them treatment options. So when you take a look at the fact that some diagnoses are disappearing in [ph] V28 (34:46), some are having their risk adjustment factor lowered, some are actually increasing those diagnoses that tend to be bread and butter through the PCP, not sort of an army of nurses going on a fishing expedition. Those will tend to do very, very well in this new model, which I think is sort of confirmatory of our approach, which is to invest in primary care and primary care relationships, which is why I think we feel pretty good about what the next couple of years look like.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

Okay. Well, fantastic. I think that's a great place to leave it. Thank you very much for your time. Thanks for coming.

Timothy S. Bensley

Chief Financial Officer & Executive Vice President, Agilon Health, Inc.

Thanks, Steve.

Benjamin Kornitzer

Chief Medical & Quality Officer, Agilon Health, Inc.

Thanks so much.