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Agilon Health, Inc. (AGL)

Q2 2024 Earnings Call

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MANAGEMENT DISCUSSION SECTION

Operator: Hello, and welcome to the agilon health Second Quarter 2024 Earnings Conference. My name is Eliot, and I'll be coordinating your call today. [Operator Instructions]

I'd now like to hand over to Leland Thomas. Please go ahead.

Leland Thomas

Senior Manager-Investor Relations, Agilon Health, Inc.

Thank you, operator. Good afternoon, and welcome to the call. With me is our CEO, Steve Sell; and our CFO, Jeff Schwaneke. Following our prepared remarks, we will conduct a Q&A session.

Before we begin, I'd like to remind you that our remarks and responses to questions may include forward-looking statements. Actual results may differ materially from those stated or implied by forward-looking statements due to risks and uncertainties associated with our business. These risks and uncertainties are discussed in our SEC filings. Please note that we assume no obligations to update any forward-looking statements. Additionally, certain financial measures we will discuss in this call are non-GAAP financial measures. We believe that providing these measures helps investors gain a better and more complete understanding of our financial results, and is consistent with how management views our financial results. A reconciliation for these non-GAAP financial measures to the most comparable GAAP measures are available in the earnings press release and Form 8-K filed with the SEC.

And with that, let me turn things over to Steve.

Steven J. Sell

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

Thanks, Leland. Good afternoon, and thank you for joining us. On today's call, I would like to walk you through the following elements: our Q2 results and forward guidance, including our latest outlook and utilization; the tangible and rapid progress we are making against our performance action plan; and important context around a series of recent organizational changes within our company.

Turning to our second quarter results. MA membership grew 38% year-over-year to 513,000 members. and MA revenue grew 39% to $1.5 billion. These results were at the lower-end of our guidance range, reflecting stronger-than-expected growth, offset by the termination of select unprofitable payor group contracts retroactive to January 1 versus our previously communicated forecast of termination dates at the end of the second quarter. As a result of our strong core membership growth, we are raising our full-year membership guidance to a midpoint of 519,000 members, while modestly lowering our full-year revenue guidance due to a series of factors, including the retroactive contract terminations.

The second quarter medical margin was $106 million, which translates to $69 per member per month, and 7.1% of revenue. These amounts were in line or slightly below the midpoint of our guidance range, partially due to our decision to book a higher 7.3% Q2 cost trend versus our guidance of 6.8%. We continue to take a prudent posture on in-quarter cost trends until data invisibility prove otherwise. Year-to-date, medical margin was $263 million. This amount also reflects the contract exits mentioned above. We are maintaining our full-year medical

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margin guidance at $400 million to $450 million, but expect to be towards the lower-end of this range as lower revenue will partially be offset by several factors, including higher volume and better payor arrangements.

Adjusted EBITDA for the second quarter was minus $3 million, putting it at the high-end of our guidance range, largely due to lower operations costs and some timing differences on new partner incentive payments, offset by slightly lower MA medical margins.

On a year-to-date basis, adjusted EBITDA was $26 million. For the full year, we are maintaining our adjusted EBITDA guidance range, reflecting lower MA medical margins, offset by better overall market entry costs. Our Q2 results and guidance for the rest of the year assumes that medical cost trends remain at elevated levels, with Part B drugs and inpatient medical admissions being the principal driver, pay claims data for our largest national payors, which are relatively complete through April, indicate that cost trends for the first quarter have restated favorably, and moderated further through the second quarter, although we have recorded a slightly higher Q2 cost trend relative to our prior guidance. This decline in trend line from Q1 to Q2 is also consistent with our real-time indicators, including our expanded use of payor census data, which indicates that inpatient utilization was down quarter-to-quarter with some intra-quarter variability. While these indicators are early, we view these data points as encouraging relative to where we book Q2 and our guidance trend assumptions.

Turning to our performance action plan, we are making tangible progress executing our plan, which positions us to accelerate performance and profitability. As a reminder, our plan includes the following four elements: one, refining our strong payor relationships; two, increasing the engagement of our primary care doctors to narrow variability; three, improving data visibility and analytics; and four, accelerating our operating efficiency.

Let me provide a few updates, starting with our payor relationships. As discussed on our last call, our physician partnerships are critically important to payors as a key part of their network and value-based care strategies. Ongoing changes in the environment continue to drive productive discussions with health plans reflected in our year-to-date results and second half forecasts. These discussions include off-cycle percentage of premium rate increases to reflect higher costs from payor bids and macro utilization, in-year 2024 relief for payor-specific issues, and three, exiting unprofitable MA contracts. As previously discussed, each health plan contract change has been and will be made in close collaboration with our local physician partners.

Most of our discussions with health plans have focused on 2025, specifically the scope and magnitude of our 2025 risk arrangements and the payor's respective bid filings. These discussions continue, and in the next few months will be a critical period for firming up our network payor and product mix for the coming year.

Turning to our work with our physician partners to reduce PCP variability in delivering care. We have made great progress in educating and supporting PCPs in caring for their highest-risk patients. Across 20-plus markets and approximately 75% of our primary care doctors, we have initiated an active panel review with the local medical director and care team, helping each PCP, one, understand and benchmark their performance in our total care model, two, create clear action plans for their highest-risk patients, which drive 50% of our overall spend, and three, identify any operational issues that may be inhibiting performance. The early results from our scaled markets that have implemented this process are encouraging. We are seeing an 8% average reduction in ER and hospital admin events for high-risk patients when we compare January and February to May of this year. By comparison, markets that have not implemented this process are seeing no change in admin events for their high-risk patients.

To accelerate and further support this process, we've invested in adding executive medical director positions to guide our local medical directors, and have filled these positions from experienced primary care leaders in our

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network. While it is very early in both the execution and measurement of this focused PCP activity, the results reinforce the potential of agilon's network of engaged, informed and appropriately supported primary care doctors to deliver differentiated cost and quality results for senior high-risk patients.

Turning to data visibility and analytics, we are continuing our financial data pipeline implementation, and have approximately 75% of our total lives onboarded. We remain on track to onboard the remaining balance of member data as we move through the third quarter and full year. This quarter, we also moved all partner administrative data into our new data lake. This combined health plan and partner data visibility is a vital component of our cost and quality management strategy, since our data pipeline enables internal teams to process and analyze medical cost trends in detail by payor and service category faster.

With this increased visibility, longitudinal analysis of performance such as disease state, cohort maturation and patient complexity inform PCPs to deliver differentiated cost and quality results for their high-risk patients. Similarly, our finance teams have a more comprehensive payor-level analysis of revenue, risk adjustment, medical expenses and product mix, which allows us to better manage payor contracts, and understand how payor decisions affect overall agilon performance. We are pleased with this progress so far, and expect to continue to refine how we incorporate this improved visibility into our clinical, operational and financial functions.

Finally, we have made significant strides through accelerated centralization and better use of technology to reduce our platform's support to approximately 3% of revenues, reflecting a 110-basis-point year-over-year improvement. On the organizational side, I am encouraged by the recent moves that have strengthened our team, and positioned our network of physician partners to further differentiate our performance in this dynamic environment. First, just over a month ago, we welcomed Jeff Schwaneke as our new CFO. Jeff brings a deep set of experience within managed care as Centene's former CFO, and previously served on our board of directors. Jeff's positive impact on our management team and the broader organization is already being felt, and I am very appreciative that he is in the CFO chair. Similarly, on July 10, we announced Dr. Karthik Rao as our Chief Medical Officer, co-leading our clinical strategy and overseeing network performance alongside agilon's Chief Clinical Officer, Dr. Kevin Spencer. Together, Kevin and Karthik have revamped the critical roles of our regional and market medical directors, and strengthened our system to provide information to each PCP on the identification and care management of their senior patients with a particular emphasis on their most complex patients.

This work is at the heart of what differentiates our credibility with our partner physicians. Today, we announced in our 10-Q filing that Veeral Desai, our Chief Strategy and Development Officer, will assume a new long-term strategic advisor role focused on future growth opportunities and payor strategies for the company. I am pleased we will continue to benefit from Veeral's deep understanding of our business model and commitment to our mission. Given the importance of our health plan relationships and strategy execution, our payor team will now report directly to me. This team will be led by Sarah Mokover, a veteran senior leader within agilon, who has extensive experience in our business model and strong relationships with our payor partners.

In closing, we are making continued progress towards our vision of enabling primary care doctors to transform the delivery of senior patient healthcare in their communities. The success we are seeing with payors and the higher-than-expected growth in both PCPs and senior patients on our platform are important indicators of the unique position we've established in the scaled management of full-risk care across 13 states and 30-plus communities. While the environment for Medicare Advantage remains challenging in the near term, we remain disciplined in our focus to differentially manage controllable costs and receive equitable reimbursement, which should only strengthen our relative position to physicians and health plans.

With that, let me turn the call over to Jeff.

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Jeffrey A. Schwaneke

Chief Financial Officer, Agilon Health, Inc.

Thanks, Steve. And good afternoon. I'm glad to be here, and be in the CFO seat again, and very excited to be at the company.

Just a couple of thoughts before I dig into the financials for this quarter. Being involved in agilon over the last two years as a director solidified my belief in the agilon model, and how it is transforming healthcare for physicians and patients. As many of you know, I have significant experience in the payor space managing high-growth companies that assume risk, and I hope to bring that experience here. My goal is to help agilon continue to enable physicians to transform healthcare in their communities, as well as meet the high demand that exists for doing so. I've now been in this role for almost a month, and have had the tremendous support of both Tim, who has remained with us in an advisory role, as well as agilon's full finance team, which remains in place. During this time as I am still new to the role, I will aim to answer all that I can, but understand that I am getting up to speed each day. So, I just want to thank you for your patience in advance as I become integrated with the team.

Now, for the financial details. Membership was approximately 513,000 members at the end of the second quarter, representing a year-over-year increase of 38%. Our quarter-end membership growth would have been higher without the impact of the retroactive payor contracts Steve mentioned earlier. The terminations were expected at midyear. However, we agreed with the payor to retroactively terminate the contracts back to January 1, 2024, given they had no effect on our medical margin for the six months. This reduced membership by 17,000 members, and reduced total revenues by $110 million compared to our guidance, and had no effect on medical margin during the second quarter.

Total revenues during the quarter were $1.48 billion, representing a 39% increase over the second quarter of 2023. This growth was primarily driven by the class of 2024 markets, and solid organic growth in our existing classes. Medical services expense increased to $1.37 billion, compared to $933 million in the second quarter of last year. The 47% growth compared to last year was driven by the expansion of the 2024 class, and higher utilization compared to the second quarter of last year. Our first quarter 2024 cost trend estimate is now 8.2%, down from the 9.1% that we recorded last quarter. Additionally, we have moderated our cost trend line for the year, recording a Q2 cost trend of 7.3%, compared to our previously expected 6.8%. While we don't have substantial paid claims data for Q2, we believe it prudent in this environment to assume higher trend. Ultimately, we will see how that plays out over the next several quarters.

Medical margin for the second quarter was $106 million or 7.1% of total revenue, compared to $134 million or 12.6% last year. As mentioned earlier, medical margin was closer to the low-end of our guidance range as a result of recording a higher estimated cost trend for Q2 2024. Platform support costs were $42 million and consistent with the second quarter of 2023. And geo entry costs were $5 million, representing a significant decrease from the prior year. Lower geo entry costs were primarily driven by the timing of new partner incentive payments, and the removal of a planned expansion in 2025.

ACO REACH continues to perform well, and our quarter-end membership was 132,000, which is slightly ahead of our expectations. REACH EBITDA was $11 million during the second quarter of 2024 and 2023. Adjusted EBITDA was a loss of $3 million, compared to positive $12 million last year. The year-over-year decline was driven by higher utilization experienced in the second quarter this year relative to the increased revenue. Adjusted EBITDA was better than our expectations, driven by lower medical margin that was more than offset by lower geo entry and platform support costs.

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Turning to our balance sheet and cash flow. agilon ended the quarter with cash and marketable securities of $408 million, and another $104 million of off-balance sheet cash associated with our ACO REACH entities. Cash associated with our ACO model entities includes unsettled payments, which will occur in the third quarter of this year. We used $18 million of cash during the second quarter, consistent with our expectations, reflecting the seasonality of our annual wellness visits and distributions to physician partners and settlements with payors. Our expected use of cash for the year remains unchanged at $125 million to $150 million. As we have discussed previously, our cash flow from operations improves during the second half of the year as we settle with payors for performance from the prior year. Consistent with the outlook we previously shared with you, our 2024 guidance would result in a cash usage of approximately $25 million in 2025. We continue to expect to be free cash flow positive starting in 2026 and continuing thereafter.

Turning now to our updated outlook for the full year 2024. We have raised our membership guidance range from 513,000 members to 519,000 members at the midpoint, recognizing our growth through the second quarter. We have reduced our total revenue guidance range by $125 million at the top and bottom end, reflecting several moving pieces, an increase in total revenue driven by incremental membership for the year. This increase was more than offset by several items: the retroactive termination of the contracts that we discussed at the beginning of the call, updated payor and member mix, which produced a lower overall premium yield versus expectations and lower expected risk adjustment for 2024. We have limited data regarding our 2024 risk adjustment performance from our payor partners, but the limited data we do have indicates less improvement for 2024 than we expected. We have recorded that expectation through the second quarter, and reflected that for the remainder of 2024.

We are continuing to work on ensuring our hard work around the BOI programs is accurately reflected in our risk scores. We are maintaining our medical margin guidance of $400 million to $450 million. We expect several items to partially offset the lower expected revenue for 2024. These include updated cost trends based on Q1 and Q2 results, incremental margin on the additional membership for the year, updated member mix, and our payor and other initiatives. Given this dynamic, we now expect our medical margin to be more toward the lower-end of our guidance range. We are maintaining our adjusted EBITDA guidance of negative $60 million to negative $15 million. Our adjusted EBITDA guidance remains unchanged as our medical margin near the low-end of the range is offset by lower overall geo entry and platform support costs.

With that, I think we're ready for the Q&A.

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QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] First question comes from Lisa Gill with JPMorgan. Your line is open. Please go ahead.

Lisa C. Gill
Analyst, JPMorgan Securities LLC
Q

Great. [indiscernible] (00:21:28) Good afternoon. I just wanted to start with the cost trends. Steve, I heard you talk both inpatient and Part B. First, are you seeing an impact [indiscernible] (00:21:38) on the inpatient side? And then secondly, when we think about cost trend and we think about risk adjustment as you talked about, what's the impact that you're seeing from V28 in 2024?

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

Thanks for the question, Lisa. I think when it comes to utilization, we had incorporated in our guidance a step-up in inpatient medical admits from the two midnight rule. We have seen that, and it is coming in line with kind of our expectation. As I talked about, as we look at our leading indicator data, we are seeing a slight decline in terms of those inpatient admits as we move from Q1 into Q2. And so, we're encouraged by that. But as both Jeff and I talked about, we did book up our Q2 cost trend at 7.3% versus what we previously forecasted at 6.8%, because we think that's really a prudent thing to do in this environment.

And then, as it relates to V28, we are seeing that impact in line with our expectations. We had expected roughly a 2% impact from V28, and that's about what we're seeing to-date.

Jeff, anything you'd add to that?

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.
A

No. No.

Operator: Our next question comes from Justin Lake with Wolfe Research. Your line is open. Please go ahead.

Dean Rosales
Analyst, Wolfe Research LLC
Q

Hi. This is Dean Rosales on for Justin. Any update on medical margin improvement in the 2021 and 2022 classes? Would you say those cohorts are starting to trend in that $150 to $200 medical margin range quite yet? Could you speak to the ramp there? Thank you so much.

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

So, thanks for the question, Dean. I mean, across that cohort, we do have groups and markets that are at that level. And we are seeing a step-up year-over-year on an incurred basis. On a year-over-year basis, we did we did see an improvement across all of our cohorts. So, I think we're beginning to track up, and within specifically the class of 2021 and 2022, we do have markets at that level.

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Operator: We now turn to Stephen Baxter with Wells Fargo. Your line is open. Please go ahead.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

Q

Hi. Thanks. I'm just trying to make sure that we understand the trend commentary correctly. So, Q1 looks like it's coming in better, but you're booking Q2 higher than you initially expected. So, I guess first, what are you implying your booking the back half of the year in this guidance? And I think you also discussed cost trend as an offset to the lower revenues, but then it seems like you're also discussing booking it prudently in the current environment, just trying to understand which one of those. Thank you.

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.

A

Yeah. Hey. This is Jeff. A couple of things. You're right. So, on the first quarter, 9.1% down to 8.2%. We had originally forecasted 6.8% booking it up slightly. Really, we're just moderating that trend line. And as Steve mentioned, we're just being prudent given the environment we're in. I will tell you, on the back half of the year, specifically Q3, our cost trend from our previous assumption really hasn't changed much. We're around 6% cost trend. And as you get to the fourth quarter, it's kind of hard to apply a trend from Q4 of last year. But we really looked at the PMPMs, and looking at historical seasonality of those from a cost perspective.

And so, yes, you are correct, there is a piece and a component that's driven by yield as well, right. So, we have updated cost trends with our performance in Q1 and Q2. And then, ultimately we have some premium yield there being offsetting cost piece as well. But in general, I think we're still taking a prudent posture on the back half cost trends.

Operator: Our next question comes from Ryan Daniels with William Blair. Your line is open. Please go ahead.

Ryan Daniels
Analyst, William Blair & Co. LLC

Q

Yeah. Thanks for taking the question. Steve, one for you. You talked a little bit about the new data lake. I'm curious if you can go into a bit more detail how you were using that, not in regards to how you model the financial outlook or expectations on cost, but rather how you're using that data to analyze care trends and really to intervene faster at the practice level, how you get that data to individuals, how do you move it in the workflow or get patients in when needed. Give us a little more color on that, as it seems like a big potential point. Thanks.

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

A

Yeah, Ryan, thank you. I really appreciate the question. I think our whole partnership is built around our proximity of that primary care physician. And the ability for us to be able to provide them timely information on what's happening with their senior patients, allows for earlier intervention, better enrollment in our clinical programs. And so, when I talked about our active panel management and the ability to have a discussion with a physician about their entire senior population, focus on those highest-risk patients that are driving 50% of the costs, and have active care plans.

What we've been able to do with our data lake is triangulate the data from our health plans, and they'll have senior patients in three, four, five different health plans, along with their EMR data. And so, they have the ability to look at that population, identify those most complex patients, look at what's happening across time. But really, it

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just gives us a better and faster mechanism to benchmark where they're at relative to kind of best practice in terms of dealing with the most complex patients. So, it's been very well-received. We're in the early days, as I talked about. We've been able to roll this out now in 20 of our markets to about 75% of our PCPs. I think the early results, that 8% reduction that I talked about in terms of ER and inpatient admits is encouraging. It is early, but that's a meaningful move, particularly in this elevated environment. So, that's how the technology is really tying into the partnership that we've got.

Operator: [Operator Instructions] We now turn to Elizabeth Anderson with Evercore ISI. Your line is open. Please go ahead.

Elizabeth Anderson
Analyst, Evercore ISI

Q

Hi, guys. Thanks so much for the question. Appreciate the early commentary on some of the primary care doctor engagement that you were just talking about. How do we think about that in terms of translating that into an opportunity for sort of the back half of 2024 as that continues to roll out and then kind of in the 2025-plus type category?

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

A

Great question, Elizabeth. So, it's early, I think, to Jeff's theme of being prudent. We're trying to be really measured in both how we recorded Q2, and how we're forecasting the back half. But our clinical initiatives are included in our forecast. That PCP engagement and the work around active panel management to really help them understand where they're at to develop these care plans and to remove any of the operational issues that could be in the way are part of those clinical activities. So, they're incorporated in what we think is kind of a prudent guide on the back half, but it's something that we believe really kind of differentiates our partnership and our network with PCPs, and in our ability to better manage cost trend over time.

Elizabeth Anderson
Analyst, Evercore ISI

Q

All right. Thanks.

Operator: We now turn to Andrew Mok with Barclays. Your line is open. Please go ahead.

Tiffany Yuan
Analyst, Barclays Capital, Inc.

Q

Hi, this is Tiffany on for Andrew. I was wondering if you could give a little bit more color on how discussions with payors are trending around your off-cycle premium increases and maybe quantify how much benefit you've gotten from retro relief thus far into the year?

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

A

Thanks for the question, Tiffany. I think we talked a lot about this on our last call. And what I would say is our discussions have really progressed well. The improvement we talked about in Q1 was $10 million on the full year. In the second quarter, we've been able to update you on some of these terminations previously communicated. They're now back to January 1. That has no medical margin impact, but obviously the impact on revenue and cost that Jeff talked about. But I think we're really encouraged, encouraged enough that as we look at our second half,

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we've incorporated further improvements into our guidance. We're not going to quantify that as we're in the middle of that right now, but we feel good enough, even in this prudent environment to incorporate that.

And then, I'll just say the majority of the discussions are focused on 2025. What we're going to take risk for across that time a big area of discussion is around Part B drug with the Inflation Reduction Act impact. And so, how that looks, we've talked to our payors about the desire to carve that out or to cap it. For two-thirds of our payors and one-third of our membership, we've been able to do that to-date, and we would like to expand that. So, I think the discussions are progressing well.

Operator: We now turn to Adam Ron with Bank of America. Your line is open. Please go ahead.

Adam Ron
Analyst, BofA Securities, Inc.
Q

Hey. Thanks for the question. Taking a look at the reserve metrics like DCP and completion ratio, looks like they trended in kind of the wrong direction, but completion ratio having like a pretty big swing year-over-year. And so, just wondering what's driving that and if it's related to moving to the new data pipeline. And if that's the case, how do you discern from like what's happening with core trend and the movement? So, appreciate any color around that.

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.
A

Yeah, thanks. This is Jeff. Real quick on DCP, I wouldn't say that's a good measure to use for this business because there's timing of when we get the information on the page that when we release it from our balance sheet. So, that's a different metric than you would find in a payor world. I'm not sure how you're calculating the completion factors, but in general, I guess when we looked at the data, the census data that we have shows that trends are coming down from Q1. We still show, as far as this year goes, January being the highest month and that month is relatively paid by now. And so ultimately, I think to Steve's point, we just took a prudent approach to reserving at the end of the quarter, and flattened out that trend line, right. So really, we're going from [ph] 8.2 to 7.3 versus 8.2 to 6.8 (00:33:12). So, feel good about where we are. But ultimately, we'll see how that reserve plays out over the next couple of quarters.

Operator: Our next question comes from Jailendra Singh with Truist. Your line is open. Please go ahead.

Eduardo Ron
Analyst, Truist Securities, Inc.
Q

Hi, guys. This is Eduardo Ron on for Jailendra. Thanks for taking the question. Just curious if you could provide some thoughts on the class of 2025. At this point last year, you guys gave some color around class of 2024. I know you talked about five physician groups adding more than 60,000 lives. And I think last year at this time, you sort of talked about the class of 2024 coming in like $30 to $60 PMPM, obviously just given the utilization challenges with the industry. Curious if there's any color you can provide on what your expectation would be for the class of 2025 cohort as you step into year one?

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

Eduardo, thanks for the question. I mean, I think we're really excited about the class of 2025. As you mentioned, it is five new partners. Just to mention in that there's only one new state in the class of 2025. And as we've talked

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about, there's tremendous opportunity for growth in our existing 13 state footprint, and this class of 2025 really reflects that. It also brings in incredibly strong groups, like Graves Gilbert out of Kentucky in a really well-respected group that's had a very strong ACO performance. All of the groups in this class are quite strong around that, and it's a mix of multi-specialty and primary care groups.

In terms of the starting point for 2025, I think we're going to be pretty prudent as we think about where that will land. I think it'll be within the range that you talked about. But we're probably not ready to communicate exactly where that will land as we're better reading sort of the overall utilization trends and also working through some of the rate details with payors in those markets. But again, we're quite excited, really strong class, and it's another year of strong growth.

Eduardo Ron
Analyst, Truist Securities, Inc.

Q

Thanks.

Operator: We now turn to George Hill with Deutsche Bank. Your line is open. Please go ahead.

George Hill
Analyst, Deutsche Bank Securities, Inc.

Q

Yeah. Good afternoon, guys. Thanks for taking the question. I guess I would ask about Medicare risk adjustment, and it sounds like that came in – well, first of all, I'll ask, was that a meaningful contributor or detractor to the revenue line in the quarter? From the prepared commentary, it sounds like it came in a little bit lighter, where some of the [indiscernible] (00:36:04) were all calling it out as being a positive indicator. And if I'm reading it right that it did come in a little bit lighter, can you talk about kind of what is the positive offset as it relates to the guide, and how big of an adjustment that would be?

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.

A

Yeah. Yeah. Real quick. So, we have limited information here. So, it did come in lighter. I mentioned in my prepared comments that we did record that through the six months, and then we kind of pushed that in for the rest of the year. And so, the offset in the quarter, you have higher membership than obviously we anticipated, so we trued that up. And then, we had some favorable development on Q1, partially offset by recording a higher cost trend in Q2.

For the year, I'm not going to really bifurcate I would say that what the yield component and the RAF component is just because really we just have this limited data. And so the offsets to that lower revenue, as we mentioned in the prepared commentary, was the updated cost trends, given the first and second quarter results, and margin on the additional membership that we add for the for the rest of the year, and then, of course, additional visibility, as Steve mentioned, on the payor initiatives that we have.

George Hill
Analyst, Deutsche Bank Securities, Inc.

Q

Perfect. If I could sneak in a quick follow-up. Is the $17,000 member change versus the prior guide, is that an incremental contract exit or is that kind of incremental lives rolled into the prior announced exits?

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

A

Yeah, George. No, it's contracts that we talked about before. The difference is we had expected them to be terminated at the end of Q2, and we worked it out with the payor partner to make it retroactive back to January 1. There was no medical margin impact from those. And so, that's how we agreed to do with them and obviously with our partners.

George Hill
Analyst, Deutsche Bank Securities, Inc.

Q

I got it. Thank you.

Operator: Our next question comes from Michael Ha with Baird. Your line is open. Please go ahead.

Michael Ha
Analyst, Baird

Q

Hi. Thank you. Just a quick question first then my real one. On the Star ratings recalc, I understand there wasn't much benefit to the larger payors, but my understanding is most of that benefit did happen in the smaller private plans that I think make up about a third of your revenue. So, I'm just curious if you expect some or any [indiscernible] (00:38:30) at all to flow through from your private payors' Star ratings improving?

And then, the real question, just regarding your off-cycle percent of premium rate increases, as we look forward to 2025, I know you're having this ongoing combo with the payors, and it's very nuanced, but at a super-high level, plans across the country are likely to reduce benefit basically at maximum TDC threshold that presumably should flow through as a benefit to agilon. So, just given that and given the fact that you just received rate increases this year, should we be expecting those payors to come back to the table, flip those rate increases back down to account for the benefit reductions next year? Or is it just given the IRA year three, V28, all those variables, it'd be reasonable to assume those rate increasing do hold into next year?

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

A

Michael, there's a lot in those questions that I had to write them all down. But so, I think the headline would be our value proposition to our payor partners has never been strong. They want to have more senior patients with us. They want us to do this in more markets. And I think the value that we're providing to them, the scale we're providing is allowing us to get some of the results that I've talked about in terms of our relationships with them.

As to your specifics, the Star ratings recalc is really a nominal impact for us. Less than 1% of our membership would have seen an increase up above a 4-star plan. So, it's really kind of a nothing related to forward impact. In terms of 2025 benefits, I would say that all of our private conversations are very consistent with the public comments that health plans have made about adjusting back those benefits pretty meaningfully. You are correct. Improvements in their overall margin posture would flow through to us, and we expect that that could be a tailwind as we look towards 2025.

And then, the percentage of premium increases, it's really a market by market situation looking at what was the underwriting, what's the information they provided, what were the benefit adjustments that they made or other actions that could have affected our overall cost structure or revenue structure? And so, that's how we've worked

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it with them. These are typically multiyear arrangements. And so, we're approaching 40% of our book that's being repriced this year, if not more, given some of the off-cycle adjustments.

Michael Ha
Analyst, Baird

Got it. Thank you.

Operator: We now turn to Jack Slevin with Jefferies. Your line is open. Please go ahead.

Jack Slevin
Analyst, Jefferies LLC

Hey. Thanks for taking the question, and congrats on a solid show in this quarter. Wanted to ask a couple on ACO REACH. Looking at the performance, I guess one near term, one a little bit longer term. So, if you look at the performance margins down quarter-over-quarter and down year-over-year, just trying to get a sense of what you're seeing on the utilization front, and if it feels like that's sort of the right trajectory looking to last year. And then, maybe the last one on that being, is there a difference you're seeing between the new lives you added with a lot of that growth coming this year versus lives that have been in place already or ACOs that have been in place already?

And then longer term, just seeing sort of strong performance, better margins out of that group than you're seeing in the core business. How are you feeling about the opportunity, given some of the moving pieces coming out of CMS on benchmarking and the change in the discount, and possibly the end of the model in 2026? Thanks.

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

Jack, thanks for the question. So, I think the headline is ACO REACH continues to be a really strong contributor for us. Another really strong quarter. I think we're taking a prudent posture on how we're recording the results for ACO REACH the same way we are for Medicare Advantage. To your point, we have grown, and we have new lives this year. And typically, just like in Medicare Advantage, those new lives come on closer to breakeven.

Historically, we have beaten that national benchmark by 200 to 300 basis points a year, and have another really strong 2023. This year, just to remind you, our expectation was at 100 basis points, which we thought was pretty measured. And I think we continue to feel that way. But we just want to be really prudent in terms of how we think about that.

Longer term, your question was, how do we think about kind of post-2026 and how do we think about the 2025 changes. Those changes that are coming in for 2025 were expected. We have standard ACOs, and the impact on us is relatively nominal for 2025 and for 2026. We've consistently saved money for CMS. 2022 is all that's public. We have a 9.7% gross savings rate, $107 million, $24 million to the trust fund from the agilon network within ACO REACH. So, those are all encouraging. 2023 will be public here, and we can talk more about those results. But we continue to be a very solid contributor to the overall Medicare trust fund, the savings that the government is looking for in that program.

Longer term post-2026, there is really strong bipartisan support for a full-risk vehicle for the Medicare fee for service population. That could happen a number of different ways. There could be another innovation center program. There could be a version of MSSP that has a full-risk track or other. But there is [indiscernible] (00:45:00) bipartisan support within OMB and others, people really see the power within the model. And so, I think

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we feel comfortable there's going to be a long-term program for the Medicare fee for service population, and it's going to continue to be a strong contributor for agilon and our network of partners.

Jack Slevin
Analyst, Jefferies LLC

Q

Got it. Appreciate the color.

Operator: Our next question comes from Whit Mayo with Leerink Partners. Your line is open. Please go ahead.

Whit Mayo
Analyst, Leerink Partners LLC

Q

Hey. Thanks. You guys have covered a lot. But Steve, I just had a follow-up to George's question. I guess I don't understand, like, why did you retroactively cancel to 01/01? Why not just say, we're going to in this contract on 07/01? I'm not sure you get the benefit of doing it retroactive when you were providing care for those members. And then, in the 10-Q, it looks like there is minus or $54 million of negative medical costs from these numbers. Do I just take the $110 million of revenue that you've sized, divide that by a and the $50 million less premium is offset by the $50 million of cost. Is that the right way to think about this?

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

A

I'll take the first one, and Jeff can give you the technical answer about the income statement. So, why did we retro this back to 01/01? Because we have deep relationships with our payor partners and with our physician partners. And this payor partner, as we're working on some things long term, talked to us about that that would be their preferred method to do it. We are able to work it with our physician partners in a way that made sense. And we're laying the groundwork for some go-forward relationships with them that I think are really going to be positive. So, it's really based on relationship and talking with them about what made sense. But the net impact on medical margin should be zero.

But, Jeff?

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.

A

Yeah, yeah, quick bifurcation here. The $110 million was compared to our expectations, right. Because we had it in for the first six months. So, you're backing out $110 million of revenue, you're backing out $110 million of costs, and zero on the med margin, okay. In the 10-Q, what you're seeing is actually you didn't record any revenue or costs for Q2 and you're just reversing Q1, right. So, there's a split between number one is our expectations. It still gets you to the same answer. No impact for the six months. But in the 10-Q, we didn't really record anything for Q2, and we had reversed the Q1 revenue, which is why you see the $55 million.

Whit Mayo
Analyst, Leerink Partners LLC

Q

Okay. Thank you.

Operator: We now turn to David Larsen with BTIG. Your line is open. Please go ahead.

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Jenny Shen
Analyst, BTIG LLC
Q

Hi. This is Jenny Shen on for Dave Larsen. Congrats on the quarter, and thanks for taking my question. Just a clarification from me, and I apologize if you mentioned this earlier, but what is the cost trend that you need to see in the back half of 2024 in order to get to your margin and earnings guidance? And I think you mentioned that 3Q is tracking at about 6%. So, what do you need to see in 4Q? And then, as a significant step-down, what makes you confident that you'll be able to reach that? Thank you.

Jeffrey A. Schwaneke
Chief Financial Officer, Agilon Health, Inc.
A

Yeah. I think I mentioned this earlier. We didn't actually give out a cost trend for 4Q because you're trending over a quarter, which was very, very high in the prior year. So, what we did is we looked at the per member per month costs, and we trended that based on historical experience over the last two years between the quarters, so Q1, Q2, Q3 and Q4. So, we didn't give a full-year trend number. And the confidence that we have is, again, we took a prudent approach. We looked at the trended PMPMs, and we think we're in a good position there.

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

And Jenny, the only addition I would give to what Jeff added is our second half PMPM cost levels for our year two-plus markets are above our first half. So, the percentages coming down is important to understand. But I think to Jeff's point, we stepped back and looked at the PMPMs, and you're actually recording at a higher level or forecasting at a higher level than we landed in the first half.

Jenny Shen
Analyst, BTIG LLC
Q

Got it. Thank you.

Operator: Our final question comes from Daniel Grosslight with Citi. Your line is open. Please go ahead.

Daniel Grosslight
Analyst, Citigroup Global Markets, Inc.
Q

Hey, guys. Thanks for taking the question. I know it's relatively early, and, Steve, you kind of touched on this in response to a couple of different questions. But I was hoping to maybe just get your high-level thoughts on how your contract renegotiations are going for 2025. As we think about the different levers you have, increasing the percent of premium carve-outs, both on Part D and supplemental and risk corridors. Where're you seeing the most receptivity at the moment? Do you think we'll see potentially some accelerated contract terminations next year? And then, in your commentary around lower geographic entry costs, you mentioned that some of that was due to a removal of plan expansion in 2025. I was just hoping to get a little more detail on that as well.

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

Sure. So, on payor discussions for 2025, it's early, I think, we're just getting visibility here. And like I said, the next few months will really dictate kind of our payor and product mix for next year. But understanding those bids will have a major impact in terms of where we land on percentage of premium, where we land on carving out or capping things like Part D or supplemental benefits. And it varies somewhat by payors. But I think we're encouraged. I think we have very deep relationships with these payors, and we're going to work with them for a

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long time, just like we work with our physician partners across a 20-year exclusive joint venture partnership. So, I think we're encouraged around those.

Where is the greatest area of progress or receptivity? It varies based on market, and on payor. I mean, the three categories I talked about are all things that we've sort of addressed with a different payor and a different market, depending upon the circumstances. So, I just laid out those categories as areas that we'll continue to work with them on.

The geo entry costs, Jeff talked about some favorability around timing. When we built our budget for this year, we had the prospect of another partner coming onboard for 2025. We've made a decision to push that out as we work with payors on it would be a new state. Can we get that market and those payor agreements to a place that makes sense? And we just agreed with that partner to pause that activity until that became clear. And so, with that clarity, we've reflected that in the geo entry, not just what we booked in the quarter, but the forecast for the second half.

Daniel Grosslight
Analyst, Citigroup Global Markets, Inc.

Makes sense. Thank you.

Operator: Ladies and gentlemen, we have no further questions. So, this concludes our Q&A and today's conference call. We'd like to thank you for your participation. You may now disconnect your lines.

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