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Agilon Health, Inc. (AGL)

Q3 2024 Earnings Call

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MANAGEMENT DISCUSSION SECTION

Operator: Good afternoon and thank you for joining the agilon health Third Quarter 2024 Earnings Conference Call. My name is Kate and I will be the moderator for today's call. At this time, all lines are in a listen-only mode and will be until the question-and-answer portion of the call. [Operator Instructions]

I would now like to turn the call over to Leland Thomas with agilon health. Leland, you may proceed.

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 obligation 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 of these non-GAAP financial measures to the most comparable GAAP measure is 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 & 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. One, an overview of our third quarter financial results and updated 2024 guidance. Two, the key actions we are taking to drive improved profitability, improve execution, and further strengthen our business. Three, despite the challenges of the last year, the underlying strength of our core business fundamentals and demand from payors and physicians. And four, the factors impacting our jumping off point for 2025, including an improved business mix exiting 2024.

Before I dive in, let me provide some context. We are clearly disappointed with the results we are sharing today and expect to drive meaningful improvement in the future, but we believe our core business is strong and we are taking the necessary actions to continue to strengthen the platform, improve execution, and manage through a challenging environment against the backdrop of long-term demand for improved cost and quality performance led by primary care doctors.

Our Q3 report and updated guide reflect additional information from our payors and a new perspective from our new CFO with the goal of capturing known risks and providing a solid foundation from which to build. Against this backdrop, we believe in the value proposition for our network and platform to be a sustainable performance vehicle for physicians and payors in full-risk value-based care.

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Pursuing this long-term vision has required some tough near-term decisions to exit selected partnerships and narrow the footprint of health plans we will work with in 2025. Our positioning for long-term sustainability includes a current cash position and cash flow management levers intended to allow us to weather the storm even as we take actions to accelerate the path to profitability and positive cash flow. Finally, we see recent events like an increased set of Star's cut points that raise the bar on the importance of quality performance and another reduction in the physician fee schedule that pressures doctor practices as indicators that the move to value will only increase in the coming years.

Now, turning to our third quarter results, MA membership continued its growth trend, increasing 37% year-over-year to 525,000 members, driven by stronger than expected same geography growth and the continued expansion of our new partner class. Total revenue grew 28% to $1.45 billion albeit on lower than forecasted premium yield. We are raising our full year membership guidance from 519,000 to 527,000 members and increasing our full year revenue guidance from $6.025 billion to $6.057 billion. And I will provide you with the projected end of year impact on membership and revenue from the decision to exit selected partnerships and payor contracts.

Third quarter medical margin was a loss of $58 million or minus $36 per member per month, which was below our expectations due to three factors: prior period revenue settlements with payors primarily tied to risk adjustments in Part D, a reduction in expected 2024 revenue from lower than projected risk adjustment, and higher than forecasted medical expenses. Our reported Q3 medical costs reflect an updated view on trend and seasonality across the year, with Q1 developing more favorably, unfavorable development from Q2, and an increased Q3 cost trend estimate. We continue to take a prudent posture on in-quarter cost trends until our leading indicator census data indicates otherwise.

In terms of medical margin guidance, we are lowering our 2024 medical margin guide to $225 million compared to our previous guidance at the low end of the $400 million to $450 million range. Of note, we have recognized approximately $100 million of negative medical margin through the third quarter from 2023 and earlier periods. Accordingly, we believe the medical margin step off point for next year is now about $325 million before the impact of the strategic actions that we are announcing today and other in-process actions.

Adjusted EBITDA loss for the third quarter was minus $96 million due to lower MA medical margin. For the full year 2024, we are lowering our adjusted EBITDA guidance range, reflecting Q3 results and a Q4 forecast of lower risk adjustment revenue and an elevated medical expense environment. While the environment is challenging and the results for the current period are disappointing, a deeper look at our performance reveals a strong core business with solid fundamentals, an increasingly relevant value proposition, and a significant total addressable market in need of a better solution.

We are encouraged by a number of factors. First, greater than 80% of our Year 1+ partnerships are producing positive market-level, MA-adjusted EBITDA on an incurred basis despite the macro headwind and producing meaningful distributions to our partner practices. Notably, our Class of 2024 is performing at the high end of our typical year one market medical margin range as these newer partners benefit from platform maturation and network learnings.

We see high demand from payors and partners reflected in our consistent quarterly additions of new doctors and members, and our Class of 2025 should add approximately 45,000 members. The recently released Star scores for 2025 reinforce our value to payors as every partner minus one on the platform in measurement year 2023 scored above the critical 4-star threshold. In a majority of our partners, we're above 4.25 stars. Our ACO REACH

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results show our network as a top performer in terms of quality and meaningful gross savings to CMS, driven by an overall cost trend, nearly 300 basis points better than the benchmark average.

Despite these strengths, we have areas of exposure to factors like Part D and supplemental benefit risk, and we have a small subset of partnerships in need of meaningful improvement. With this assessment and against the backdrop of a challenging environment, we are announcing the following actions in process.

One, to exit two partnerships and approximately 10% of our payor contracts. Two, to reduce the beta on elements outside our control by narrowing our 2025 exposure to Part D risk. And three, to delay the onboarding of one Class of 2025 physician partner given local payor dynamics.

First, across a network of 26 partnerships and a year-end projected 527,000 MA members and 128,000 REACH members, we have mutually decided to exit two partnerships experiencing substantial adjusted EBITDA losses in 2024. In addition to the payor contracts associated with the exited partnerships, we will also be non-renewing several unprofitable payor contracts in continuing partnerships. These actions will reduce our projected end of year 2024 membership by roughly 45,000 to 75,000 members, and our annualized revenue by approximately $470 million to $785 million. We are working to exit each of these contracts as of December 31, 2024 although a few of them may continue through 2025.

These were not easy decisions, but in this challenging environment, we concluded these partnerships would take too long to reach profitability and we needed to consider the health and future success of the broader network. As always, these decisions were made in close collaboration with our physician partners.

Second, against our long-term goal of reducing the beta in our business, we now expect for 2025 more than 50% of our membership will have some type of risk mitigation for Part D through carve-outs, corridor or other risk mitigation strategies. Our recent discussions reinforce the unique value levers that agilon's network brings payors in terms of quality scores above and Part C medical trends below their broader fee-for-service network. With the evolving environment, we believe that how we manage Part D risk in partnership with our payors is a critical decision.

Third, in close collaboration with the 2025 physician partner, the decision was made to delay the onboarding of this group until financial data exchange with three regional payors in that market improve. We will continue to work closely with this partner and the regional payors to monitor the local dynamics and reassess inclusion in our 2026 partnership class.

The net effect of these actions is that we have improved our baseline market mix exiting 2024 both in terms of run rate and reduced beta, which should yield a stronger jumping off point for 2025. As indicated earlier, we believe the membership step off for 2025 will be 452,000 to 482,000 MA members before the addition of 45,000 MA members from the Class of 2025. And based on our revised guidance, the medical margin step off point for next year is now about $325 million before the key actions I have described.

The investor materials on our website provide more information on the impact of these actions on membership, revenue, and our market mix. And we'll be dimensioning the expected margin lift in more detail early next year.

In addition to these actions, we see a series of factors and execution opportunities that will impact our 2025 performance. These include repricing 40% of our membership for a January 2025 renewal. Across multiple markets and payors, we are seeing an improved percentage of premium economic terms as well as additional incentive dollars tied to our partner's quality performance.

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Payor bid information. We have received updated payor bid information for 90-plus percent of our membership. While each bid varies by market and payor, the composite indicates these bids will be a blended tailwind for next year.

Improved burden of illness assessment. We see a clear execution opportunity for improvement among our internal teams, partners, and payors to ensure that the verified burden of illness or risk adjustment is appropriately reflective of the acuity mix of our population. This work involves tight integration with our partners' electronic medical records; the identification of new, complex conditions; a thorough physician and care team review; and a tight payor data exchange and feedback loop. Our expanded payor data pipeline will be instrumental in strengthening our collective performance.

Improved PCP engagement. The key performance driver for the Class of 2024 is seen in the tight grouping of the primary care doctors across our partnerships, translating into improved medical cost, quality, and assessed burden of illness performance. The expansion of our quarterly active panel management reviews to 20-plus markets, reinforced by an expanded team of regional medical directors, should be a tailwind heading into next year.

Data visibility both in terms of leading indicators and detailed member level revenue and cost information is such an important lever in our execution of a multi-payor market-based strategy. In 2024, we have made meaningful progress on both fronts with 85-plus percent of total members in our financial data pipeline with a detailed member view and 80-plus percent of members with payor census data that provides us a two-week lag view on in-patient utilization.

In closing, and before I turn it over to Jeff, I want to reiterate that the value of our business model remains strong with both physicians and payors, and we continue to be confident in the progress we are making to enable primary care doctors in this volatile macro environment. We have made important decisions that strengthen our business and we believe this will support near and long-term performance and the path to profitability as the macro environment improves.

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

Jeffrey A. Schwaneke

Chief Financial Officer, Agilon Health, Inc.

Thanks, Steve. Good evening. I'll start by reviewing our overall financial performance, review highlights from our third quarter results, and discuss our guidance for the full year 2024 while framing our thoughts on 2025. Now that I had been here for almost four months, I've had the opportunity to complete a comprehensive review of our organization, gaining valuable insights and observations into the business model and identifying areas in need of improvement. These findings, in addition to the most recent data we've received, detailing our performance in risk adjustment, prior period development, and higher contingent utilization have changed our view for the third quarter 2024 and the full year. As a result, we have recorded significant adjustments during the third quarter and accordingly have made revisions to our full year 2024 expectations.

As Steve highlighted, the demand for the value we create for our payor and provider partners has never been higher. We have proven the business model drives higher quality healthcare and lower overall costs even in a challenging macro environment. However, it is not without challenges. We continue to improve our back end process and invest in data timeliness and quality that will drive better visibility on our performance. We believe these improvements in combination with contracting changes surrounding Part D will enhance our ability to

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reduce volatility around risk adjustment, Part D, and medical costs. Excluding prior period development for 2023 and prior dates of service, we believe 2024 represents a solid foundation to grow the top and bottom line heading into 2025.

Now, for the financial details from the quarter, Medicare Advantage membership was approximately 525,000 members at the end of the third quarter, representing a year-over-year increase of 37%. Year-over-year growth was driven by membership Class of 2024 with strong same geography growth.

Total revenues increased 28% on a year-over-year basis to $1.45 billion during the third quarter. Year-to-date, revenues increased 39% to $4.53 billion. This growth was primarily driven by the Class of 2024 markets and solid organic growth in our existing classes.

Third quarter medical service expense increased to $1.51 billion compared to $1.02 billion last year. The 47% growth compared to last year was driven by the expansion of the 2024 class and higher utilization compared to the third quarter of last year.

Our first quarter 2024 cost trend estimate is now 7.4%, down from the 8.2% that we reported last quarter. Our second quarter 2024 trend assumption increased to 8.2% versus our previous assumption of 7.3%. Our third quarter 2024 cost trend assumption is now 9.1% versus our initial assumption of 6%, recognizing that we don't have substantial paid claims data for Q3.

Given the utilization environment we have seen this year, we have assumed higher costs for the fourth quarter and increased our cost assumptions by an incremental $25 million relative to our prior expectations. We now expect the fourth quarter cost trends to be 5.2% off a high cost quarter last year.

Medical margin for the third quarter was a loss of $58 million compared to positive medical margin of $111 million in 2023. As mentioned earlier, medical margin was below our guidance range as a result of several items. First, we lowered our year-to-date revenues by $65 million, driven by lower than expected risk adjustment performance for 2024. This is based on mid-year risk adjustment information we received from our payor partners during the third quarter. Second, we recognized $60 million of unfavorable prior period development related to 2023 and prior dates of service driven primarily by updated statement data regarding Part D costs and final risk adjustment information for 2023. And lastly, we recorded additional medical expense of $25 million during the quarter driven by the continuation of elevated current year medical costs.

Platform support costs were $42 million and consistent with the third quarter of 2023 and the second quarter of 2024 and represent about 3% of revenues, in line with our target for the year. Geography entry costs were down 60% at $7 million compared to $18 million in 2023. Geography entry costs favorability was driven by continued diligence on operating expenses, lower capital support funding needs, and a delay of a market expansion from 2025 to 2026.

Third quarter adjusted EBITDA of negative $96 million compared to positive $6 million in 2023 is attributable to trends previously discussed weighing on medical margin. ACO model entities continue to perform well, and our quarter end membership was 132,000, which is slightly ahead of our expectations. ACO model adjusted EBITDA was $12 million versus $18 million in the third quarter of 2023. The year-over-year decline was driven by higher utilization experienced in the third quarter this year relative to the increased revenue.

Turning to our balance sheet and cash flow, agilon ended the quarter with cash and marketable securities of $399 million and another $113 million of off-balance sheet cash held by our ACO model entities. As a reminder, cash

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held by ACO model entities will fluctuate based on inflows and outflows related to operations of the program. This cash includes unsettled payments, which are expected to occur in the fourth quarter of this year.

We used $9 million of cash during the third 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 is now approximately $165 million versus our previous expectations of $125 million to $150 million. This is driven by the increase in prior period development we recognized this quarter, which has an in-year cash flow impact. 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.

Additionally, given the lower expectations for 2024 performance, we have updated our 2025 cash usage to approximately $110 million. We expect to end the year with approximately a $365 million of cash on the balance sheet inclusive of the off-balance sheet cash associated with the ACO model entities. We continue to believe we have adequate capital on the balance sheet to achieve breakeven cash flow, which we now expect to occur in 2027.

Turning now to our updated outlook for the full year 2024, we have raised our MA membership guidance range to 527,000 members from 519,000 members at the midpoint, recognizing our growth through the third quarter. We have increased the midpoint of our total revenue guidance range by $32 million, which reflects lower risk adjustment offset by incremental membership for the year.

Given the previously discussed third quarter 2024 medical margin headwinds and our updated fourth quarter 2024 assumptions, we are lowering our full year 2024 medical margin midpoint to $225 million compared to our previous guidance of the low end of $400 million to $450 million. Additionally, we are lowering our adjusted EBITDA guidance range to a negative $135 million to a negative $155 million. As we have demonstrated, we continue to make the appropriate adjustments necessary to improve profitability, which in the past has included exiting markets, renegotiating unfavorable contracts, and optimizing operating cost.

As we begin to think about 2025, when you exclude roughly $100 million of unfavorable development from prior years, we believe the 2025 step off point for medical margin is around $325 million. This is before the impact of any of the measures we are taking to improve profitability, including the anticipated exit of two unprofitable partnerships and underperforming contracts, reduction in Part D exposure, and other strategic actions. Given the actions we are taking in 2024, we want to emphasize that 2025 will likely represent a turning point for the company.

With that, let me turn it back to Steve for some closing comments.

Steven J. Sell

Chief Executive Officer & Director, Agilon Health, Inc.

Thanks, Jeff. In summary, we readily acknowledge that 2024 has not unfolded as we expected and we are taking the necessary steps to address that. We believe that the decisive actions we have taken this quarter coupled with the continued execution of our targeted action plan will result in improved performance versus our 2024 jumping off point. We look forward to updating you as these actions are finalized over the next few quarters.

With that, let's turn to Q&A.

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QUESTION AND ANSWER SECTION

Operator: We will now begin the question-and-answer session. [Operator Instructions] The first question will come from the line of Lisa Gill with JPMorgan. Lisa, your line is now open.

Lisa C. Gill
Analyst, JPMorgan Securities LLC

Q

Thanks very much and thanks for all the details. Steve, I just want to go back to some of your comments and talking about 2025. You talked about repricing 40% of your book of business. You talked about an improvement and then renewal percentage as well as incentives. Can you give us an idea like what that looks like across the 40%? And how do I think about the other 60%? Is it that there wasn't an issue with the other 60% or this is all that you were able to negotiate as we think about 2025?

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

A

Yeah. Thanks for the question, Lisa. So, I think we feel very good about the progress we've made with payors since our last call a quarter ago. The repricing that you're specifically asking about was for the 40% of the membership and the book that was up for renewal. So, that's the significance of the 40%. I think what we're seeing is not only improved economic or percentage of premium terms, but increasingly because of the importance of quality, a upside incentive for better quality performance and I shared with you the strength that we saw in the recently released Star's results. So, our value proposition to payors is reflected within that.

The other piece is Part D. That expands across more than just that 40% of membership and as I said, we've got multiple negotiations that have progressed pretty far. At this point, we're saying at least 50% or more will have some sort of mitigation on Part D risk, whether that's a carve- out, a corridor or some other arrangements.

One other area I'll just call out is in this environment that we're in and given the value prop that we have to our payors, we are seeing the ability to have year one alternative economic arrangements for our year one partners as they come on with no downside, a care management fee that then is a glide path into a risk arrangement. Once we've been able to get all of the data that we need with these local payors, which is becomes such a critical aspect of success in our model. So, that's the flavor on the negotiation.

The other piece is the payor bids that have been received, Lisa. We've got 90-plus percent of our membership in very detailed bids and while we're not giving an overall dimension of that, we are saying that's going to be a favorable tailwind for us. And it varies pretty dramatically based on market and based on payor.

Operator: The next question will come from the line of Justin Lake with Wolfe Research. Justin, your line is now open.

Justin Lake
Analyst, Wolfe Research LLC

Q

Thanks. First question I wanted to ask is, Jeff, first of all, welcome. Appreciate all the detail here. On the trend numbers you gave us, if I have it correctly, you had – you said that the trend is 10% the third quarter and you're assuming 5% in the fourth quarter. Is that right?

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

What we said, Justin, was we originally assumed 6% in the third quarter, which is now a little over 9%, 9.1%. So, Q3 went from 6% to 9.1%. In Q4, 5.2%. And you have to remember...

Justin Lake
Analyst, Wolfe Research LLC
Q

Okay. So, obviously...

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

Yeah, that was based off a high step off last year, right?

Justin Lake
Analyst, Wolfe Research LLC
Q

Yeah. So, that's what I was going to ask. Is there any way given that we don't have visibility to that step off, can you maybe share a PMPM number with us in the third quarter versus what you're assuming in the fourth quarter?

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

Yeah, I will say that the fourth quarter...

Justin Lake
Analyst, Wolfe Research LLC
Q

[indiscernible] (31:06) changed, something like that?

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

Yeah. Yeah. Yeah. I will tell you that the fourth quarter is – and we used history for this, right? So, we went back several years looking at how the fourth quarter plays out compared to all the other quarters, Q1, 2, 3. The fourth quarter will be the highest quarter of the year. So, we've got the PMPM recorded up I would say roughly 7% higher than Q1 and 3% higher than Q3, I believe. Yeah, roughly 3% higher than Q3. So, generally, we've looked at historical seasonality and that's what we have in the forecast. And obviously, we added dollars there, $25 million to that number.

Justin Lake
Analyst, Wolfe Research LLC
Q

Okay. And I'd love to get an update on what CMS is assuming for fee-for-service trend. Can you give us that number from – what is CMS using for the ACO trend for 2024 at the moment?

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

Yeah, I don't have that number off the top of my head, Justin. We'll get back to you.

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Operator: Thank you. The next question will come from the line of Adam Ron with Bank of America. Adam, your line is now open.

Adam Ron
Analyst, BofA Securities, Inc.

Q

Hey, thanks for the question. So, sorry if I could have stitched this together from your comments, but there were a lot of numbers and I want to make sure I got this. So, what is the amount of cash you expect to end 2024 with? And then if adjusted EBITDA this year are going to be negative $145 million, does that mean next year's cash burn should be roughly equal to that? And then on the ACO REACH cash, do you have to exit ACO REACH to get that cash and wouldn't exiting also be a cash drag?

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

A

No, just a couple things. So, I'll just go through the numbers that we quoted. So, number one, we said we're going to end the year at roughly $365 million. That includes the ACO cash. Now, you see the $110 million in the script, but in reality, after we make those payments in the fourth quarter, ACO cash is roughly about $35 million. So, the $365 million we end the year includes about $35 million of ACO cash.

The other thing that we indicated is that based on this year's performance, next year, we think our cash usage is going to be $110 million. So, we originally had $25 million. Now, the update, it's $110 million of cash burn and to your last question, you do not have to get out of the program to get the cash. There are mechanisms that we have where effectively we're charging an administrative fee to the ACOs that monetize that cash.

Adam Ron
Analyst, BofA Securities, Inc.

Q

Okay.

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

A

And Adam...

[indiscernible] (34:01)

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

A

I was just going to say I think we seen sit in a strong cash position and part of the actions we're taking today are intended to really accelerate our path to profitability and cash flow positive and obviously impact the cash needs on a go-forward.

Adam Ron
Analyst, BofA Securities, Inc.

Q

Yeah. And around that, if you could quantify a few things. So, you mentioned that in 2025 on 90% of your members, you're seeing a net tailwind from the bids that you saw from payors. So, I'm wondering if there's any number you could give us, maybe like an amount of supplemental benefit that you think would flow through that you would get?

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And then the second piece is in the slides that you posted, there's a bar that shows the size – or it's like representing the contracts you expect to exit. It looks like it's around $20 million just by like eyeballing it. Is that the right way to think about it? Thanks.

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

So, Adam, thanks for the questions. On the payor bids, I think what we're comfortable sharing is we've got them for 90-plus percent of our membership and that is a net tailwind for next year at a composite basis. And we're not dimensioning beyond that.

In terms of the two partnerships that we're leaving and the impact on the membership and revenue, we do dimension that. From a margin perspective, what I said in my prepared remarks is we'll share that with you early next year as we finalize 2024 and we finalize all of that. So, we are not giving you a number on that today, but calling out that it will obviously be a positive.

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

Yeah. Yeah, I think just real quick, I mean, obviously we wouldn't be taking those actions if it wasn't meaningful. So, it's meaningful but I wouldn't use that bar as some representation of the amount.

Operator: The next question will come from the line of George Hill with Deutsche Bank. George, your line is now open.

George Hill
Analyst, Deutsche Bank Securities, Inc.
Q

Yeah, good morning. Kind of a follow-up as it relates to the $325 million jumping off point for medical margin. I guess is Steve, is the right way to think about that is that that's the baseline for 2025 expectations? And then that would basically imply that the business is going to be kind of breakeven on or the – I should say the expectation is the business might be breakeven, modestly negative on a reported basis in 2025?

And I guess I would ask a little bit more about like can you tell us – you talked about like the – I'll call it the membership erosion and the medical management dollar erosion. Kind of what are some of the other assumptions that kind of underline or underpin that $325 million step off? Like the way I'm looking at it is thinking about is like that's the step off for 2025. Tell me if you're not even thinking about that, [indiscernible] (36:56).

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

Yeah, yeah. Real quick, George. It's pretty simple. Effectively, what we're saying is if you take our 2024 performance and you back out all the prior period development, that's really for 2023 dates of service. If you back out the $100 million, that's kind of what I call a run rate exiting 2024, meaning that's what the business is performing on an incurred basis exiting 2024. So, yeah. So – and this is – yeah, this is before I think the actions that obviously Steve mentioned so...

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

That's right.

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

...the exits and other things that we're doing. So, we're just trying to give you some context. If you take the out of period things out, that's kind of the baseline.

And your second question, restate that second question.

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

I'm not clear on the second part of your question, George.

George Hill
Analyst, Deutsche Bank Securities, Inc.
Q

Well, I guess the second question is if we think of the $325 million, the $325 million is kind of the – I'll call it the normalized or the adjusted adjusted medical margin for 2024.

I guess as you think about that number, I know you guys haven't given preliminary 2025 guidance yet. I guess I would just ask. From where you sit right now, what are the big moving pieces, the big puts and takes that you see as it relates to your visibility to 2025?

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

Yeah. So, I tried to call that out a little bit in my script, George. So, I think you've got that revised step off run rate at $325 million. We've got the impact from the exit of these partnerships that Adam just talked about that we're going to give you an update on early next year as we finalize that. We've got a whole host of payor activities. I would call it the repricing percentage of premium, the quality incentives.

The Part D, obviously that will be an update for next year both from a revenue and a cost perspective as we have a greater percentage of folks that have a mitigated impact from that. And then the payor bids that Adam also asked about. So, those are significant. There's the BOI improvement year-over-year and I think we think our improvement will be roughly in line with what we saw in 2024. Stars, beyond the incentives that I talked about, we'll have roughly the same amount of members in 4-star plus plans. And then obviously, there's a utilization assumption that we'll talk about more as we get closer to 2025. But those would be, I think, kind of the puts and takes.

Jeff, would you add anything to that?

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

Yeah, No, I think that covers it. I think that covers it.

Operator: Thank you. The next question will come from the line of Elizabeth Anderson with Evercore. Elizabeth, your line is now open.

Sameer Patel
Analyst, Evercore ISI
Q

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Hi, guys. This is Sameer on for Elizabeth Anderson. I just wanted to ask about the mid-year risk adjustment impact. Is there anything different that caused that this year versus prior years? It seems like it's something relatively new, at least to this degree. So, what – maybe if you could provide a little bit more color on what's driving that. Was that – presumably it wasn't like the outage with change, but just trying to understand what it was.

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

Yeah, Sameer, thanks for the question. I mean, I think our headline is we see this as a clear execution opportunity for improvement between our team and our partners and our payors. We've kind of diagnosed that gap and dimensioned it out. In 2024, on a paid 2024 basis, it's $100 million between the $65 million we've shared this quarter and the $36 million that we shared last quarter.

You are right. This has been a historical area of strength in which our revenue has restated favorably relative to what we've guided. In 2024, we had raised our expectation relative to prior [ph] three (41:04) years. That was based on a tremendous amount of activity that we had at the end of 2023 and what we found is our ultimate adoption and capture through our physician partners and our payors was lower than that. And so we see that as clear work in front of us. And the good news is this is an annual cycle. We have the same patient base that has those same conditions and there's the ability to assess and capture those for the coming year. And as I said, for 2025, I think we think our improvement will be in line with our 2024 list. For 2026, we see a larger opportunity based on the work that we're doing.

But Jeff, what would you add?

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

Yeah. I mean, I think if you just go back to like Steve mentioned, we did a lot of work in 2023. That work produced a lot of great BOI lift. We thought that was going to translate on a one-to-one basis and ultimately it didn't. We found some gaps. We're closing those gaps. We're late in the year obviously so the impact on 2025 will be minimal. But as we look to 2026, we'd really look for a step-up at that point.

Operator: Thank you. The next question will come from the line of Ryan Langston with TD Cowen. Ryan, your line is now open.

Ryan Langston
Analyst, TD Cowen
Q

Hi. Thank you. On the partnership exits, understanding you're exiting two, but it looks like there's still three that would be unprofitable. I guess what's the thought of keeping those three and if the trajectory or profitability doesn't sort of change in the next maybe 6 to 12 months, would you consider further action on those particular partnerships? Thanks.

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

Yeah, Ryan, thanks for the question. I mean, I think we feel like we have a very strong network. To your point, we've got 26 partnerships, 655,000 senior patients across REACH in MA. We've mutually decided to exit two of those. In the attachment, we show you that 5 of those 26 are not yet profitable at that market level on an EBITDA basis. I think the difference between the two and the other three is the magnitude of loss that sits within those two.

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And the timeframe that it would take to return those two partnerships to profitability and that's based on a mutual dialogue in the payor dynamic within those markets that are part of that.

Those three are much closer. We see several of those getting to profitability in 2025 and/or very close to it. So, I think it's the magnitude. I think it's the timeline and I think it's a combination of things with payors and partners that affect each one of those differently. But that's the logic behind the two out of the five.

Operator: Thank you. The next question will come from the line of Stephen Baxter with Wells Fargo. Stephen, your line is now open.

Stephen Baxter
Analyst, Wells Fargo Securities LLC

Q

Yeah. Hi. Thanks. Just a couple. First, on trends, I guess, first, what drove the revision to Q2 cost trend?

And then second, I guess can you be a little bit more specific about why you don't think we should be jumping off from [ph] last (44:36) Q4 from a trend perspective? I guess what specifically about Q4 do you view as transient or non-recurring. Or I guess said differently, like what period of history do you think represents a better seasonality pattern to modeling off of than last year? Thanks.

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

A

Yeah, a quick – I mean, obviously we get paid claims data every quarter, right, every month. So, part of the – I'd say the recast on the trend data for Q2 is more paid claim data and specifically, it looks like the month of May specifically was higher than we originally anticipated, but we're going from 7.3% to 8.2%. I would also combine that, however, with Q1, which went from 8.2% to 7.4%. And so, in general, what I'd say is those those two pretty much offset.

As far as the fourth quarter, I mean, we wouldn't use the fourth quarter because the seasonality of the business, I mean, over the years, Q1's a lot less than Q4. And we haven't given a trend number for 2025 yet. So, we're not necessarily saying that we're giving a trend number for 2025. So, I don't know if that answers your question.

Operator: Thank you. The next question will come from the line of Andrew Mok with Barclays. Andrew, your line is now open.

Andrew Mok
Analyst, Barclays Capital, Inc.

Q

Hi. Good evening. Wanted to follow-up on the negative risk adjustment. It's still not clear to me why this came in so much worse than you expected. So, is this a data issue or a forecasting issue? And it sounds like some of the operational changes and investments will take some time to implement. Would love to get an update there. And I guess how do we get comfort that you're properly accruing risk adjustment now so that this issue doesn't recur next year? Thanks.

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

A

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Yeah. Yeah. So, a couple of things. Number one, I think you have to go back and we did all this work in investment in the BOI program in 2023. The results of that investment were very strong and so that effectively led us to a risk adjustment forecast that now looking back, we had expectations higher than what's actually coming in.

And the reality is, is what Steve had mentioned is that there's gaps in the processes that we have identified and we're going to be able to close. And so I think that's effectively – the work that we did didn't translate on a one-to-one basis to the ultimate [indiscernible] (47:14) score. So, that's the first thing.

The second thing is this is a – I would say this hasn't been a historical problem, right? It's typically restated favorably. I would call this an isolated incident where we invested heavily the year before.

And then lastly on the confidence, I mean, that would be one of the reasons why I'd say we're confident in the 2024 number. The second reason is that we got the mid-year data through the payors from the government. We've tied to that data. We have looked at the history of what we've achieved on a mid-year to final [ph] RAS (47:49) lift. So, we have that baked into the calculation.

And then the other thing we did is we reached out to all of our large payors and asked what their view was on what they have in their forecast for lift between the mid-year and the final. And so, again, our job is to come up with the best estimate. We feel pretty comfortable we've got it covered.

Operator: Thank you. The next question will come from the line of Jack Slevin with Jefferies. Jack, your line is now open.

Jack Slevin
Analyst, Jefferies LLC

Q

Hey, thanks for taking the question, fairly simple one. Just looking back, I guess that you don't want to put all the moving pieces [ph] the other (48:29) 2025 as you're still sort of figuring it out. But if you try to isolate Part D and maybe if you look back to 2023, do you have maybe a sense of magnitude or – I mean, best case or an actual number, but if not, sort of a general sense of magnitude on how much Part D is weighing down on mid-margin and on EBITDA? Thanks.

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

A

Yeah. Yeah, Jack, hey. So, it is a negative impact. We're not dimensioning that today. I think there's two issues we see with the – one, is the underlying performance, but the other issue is just the lag, the amount of time it takes to close out Part D from the prior year and the visibility that we have around that, which is leading us to this goal with all of our payor partners to really mitigate our exposure to that, whether that's through this carve-out or a corridor or other mechanisms. And that's important. I mean, as I said in my remarks, how we deal with Part D risk is very important to our payor partners. Many of them say, hey, the primary care physician does have some role within it, but they agree with us that our ability to control all of it and more importantly, the ability to see the information we need to accurately forecast that is challenging.

And so that's the construct under which particularly as we step into IRA and the dollars increase to mitigate more of our membership against that. And then for the balance, just like with everything else, we're going to forecast it very, very cautiously.

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Operator: Thank you. The next question will come from the line of Michael Ha with Baird. Michael, your line is now open.

Michael Ha
Analyst, Robert W. Baird & Co., Inc.

Q

Hi. Thank you. So, I understand you have initiative in play to improve your data visibility, but in terms of just fully closing the claims lag [ph] driving (50:38) payor data exchange gap, I was wondering if you could talk more about whether there is a potential pathway to full claims delegation. It seems to me that could or would be that potential ultimate fix or sort of the panacea to your claims cost trend and risk adjustment data lag issues.

So, I want to ask. Is the technology offering you guys have set up to handle that or are there other hurdles or any other factors that would keep you from taking on full claims delegation? Thank you.

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

A

Yeah. Michael, thanks for the question. I mean, I spent a lot of years delegating in California to a number of entities that paid claims downstream. That is not a model that works in most of the country nor do most of the payors that we work with have the ability to do that.

And so the alternative is the financial data pipeline that we've been updating you on, the ability to get detailed member and claims information. That is on a – it's not a lag to the payors. It's not a lag to us. The big leap we've made is this leading indicator data, the census data that Jeff referenced that we rely on to book our trends within in the quarter that gives us on a two-day to a two-week lag, a very good idea about what's happening in the inpatient setting across our network. And so that's the big leap that we've made around that.

We continue to add other data in in terms of HIE data, lab data, pharmacy data, et cetera, that gives us a better view around that. But to be successful in these markets, we need to be able to get access to that and as I called out, if we can't get certain information from payors, we won't be working with them. And so that's affected some of the decisions that we've made, whether it's exiting contracts with payors or delaying bringing on a new partner for the Class of 2025. That was less of an issue with our partner. They were kind of ready to go. It was with those payors we couldn't get that information and we just did not feel comfortable standing it up.

Operator: Thank you. The next question will come from the line of Sean Dodge with RBC. Sean, your line is now open.

Thomas Kelliher
Analyst, RBC Capital Markets LLC

Q

Hey, good afternoon. This is Thomas Kelliher on for Sean. Thanks for taking the question. Sorry if I missed this earlier, but [ph] you all (53:12) mentioned alternative risk terms for year one markets. Can [indiscernible] (53:15) a little more detail? Is there something new that's starting in 2025? I just want to make sure I understand the distinction. Thanks.

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

A

Yeah. Thomas, thanks for the question. There is something new in 2025. I think that the headline is we provide a lot of value to our payor partners. They really want us to be with them over the long haul. In this move to value, all of them have aggressive goals about expanding more of their senior members into value.

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And so in 2025, probably for the majority of that class, we will end up with contracts for the first year that are no downside and a care management fee that gets us set up around our burden of illness work, the quality work, the clinical programs, get the right data so you can underwrite as you move into year two and beyond. And so that is new. It's a glide path into full-risk, but it's all part of this stand up in the year, and it just allows us a little bit more flex and protection based on what have been some historical data exchange issues that end up being very challenging when you're taking full-risk.

Thomas Kelliher
Analyst, RBC Capital Markets LLC

Q

Yeah, it's helpful. Thanks for the distinction.

Operator: Thank you. [Operator Instructions] The next question will come from the line of Daniel Grosslight with Citi. Daniel, your line is now open.

Daniel Grosslight
Analyst, Citigroup Global Markets, Inc.

Q

Hi, guys. Thanks for taking the question. Actually, I had a similar question to the last one on the glide path. Really two questions. One, more mechanical. The second one, a little more big picture. On the mechanical side, I assume with this glide path you don't recognize revenue on a gross basis. You recognize [ph] you've been (55:12) in that care management fee or maybe a net savings fee as revenue.

And then the bigger picture question is just on the model and if perhaps these challenges may necessitate moving away from 100% fully capitated type of model and entering into more downside protection for you or maybe just upside/downside with corridors. Any change in kind of the overall model away from 100% capitated that you're contemplating in 2025 and beyond?

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

A

So, I'll let Jeff answer the accounting question in a second, but Daniel, as we think about this, this is a glide path in the initial year with the idea of moving to full-risk over time. I think it's reflective of the challenging environment in which we're in and so there's always the possibility to extend that if we need to across a period of time. But I think we feel like full-risk, value-based care delivers the best quality and cost outcomes. It's the place of real value we have with our payors.

We need to get economics that align with that in terms of percentage of premium. We need to get incentives for the value that we bring them like the quality program that I talked about. And so that's sort of the way that we're approaching it. And we need to get data because that's one of our biggest – when we get data and we're able to align with our physician partners, we've demonstrated an ability to perform extremely well on a Part C medical trend relative to whatever that local benchmark is.

So, that's the path and how we think about it. But in this environment, this seems like a smart glide path as you bring on. I did share with you that 80-plus percent of our partnerships are already positive adjusted EBITDA at the market level even in this challenging environment. And we see the opportunity obviously for that to improve.

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

A

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Yeah. Real quick, Daniel. On the accounting issue, you're right. Yeah, it depends on the contract terms, but it could be no gross reporting so...

Operator: Thank you. At this time, there are no further questions registered in the queue so I will turn the call back over to the management team for any additional remarks.

Steven J. Sell

Chief Executive Officer & Director, Agilon Health, Inc.

Great. Thanks to all of you for joining the call. Obviously, 2024 has not unfolded the way we expected, but I think we feel very good about the actions that we've communicated today and the strength of our core business as we've communicated. So, thank you and we'll talk to you soon.

Operator: That concludes today's call. Thank you all for your participation and you may now disconnect your lines.

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