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Event Details

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Company: Agilon Health, Inc.
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Company Participants

Steven J. Sell - Agilon Health, Inc., Chief Executive Officer & Director
Jeffrey A. Schwaneke - Agilon Health, Inc., Chief Financial Officer

Other Participants

Craig Jones - Analyst

MANAGEMENT DISCUSSION SECTION

Craig Jones

Hi, everyone. My name is Craig Jones. I'm one of the healthcare analysts here at Bank of America, and I have the pleasure of hosting Steve Sell, CEO, and Jeff Schwaneke, CFO of Agilon Health. So first of all, thanks for coming. And it's very helpful for everyone if we just first just start the quick overview of Agilon's business, maybe just a few quick key differentiators versus competitors.

Steven J. Sell

Yeah. Thanks, Craig. First of all, it's great to be here. So I think our belief is the primary care physician is the best positioned within the healthcare landscape to manage total cost care and quality. But historically, they haven't had the business model to do that. And so what we've done is created a long-term exclusive partnership with primary care physicians who sit in scaled groups. Groups have been in their communities for decades, and they have a long-term relationship with their patients. So our PCP's have on average a 10-year plus relationship with their patients. And what we do is we move those physicians, their patients and their health plans from fee-for-service for the senior population into global risk in which they manage that total cost care and quality. And so that's what we think is really the differentiator, the partnership and then the long-term relationship between the PCP and the patient.

QUESTION AND ANSWER SECTION

Analyst: Craig Jones

Question – Craig Jones: Absolutely. So, I think maybe to start here, we got some interesting news out of United. I think you saw yesterday morning. You're obviously very familiar . So maybe if you could just give us what you're seeing from medical cost perspective there, what you seen year-to-date, maybe anything, quarter-to-date or any color you provide there, I think would be very helpful.

Answer – Steven J. Sell: Yeah, maybe I can give you a frame on context a little bit building on our model and Jeff can talk specifically about trends. But I think what's important is this long-term relationship with the patient and physician. And so, part of it is we look at 2025, an important data point we shared on our earnings call last week is we basically have the exact same patient base in 2025 than we had in 2024.

They've been with their physician for a long time. They've been doing the work in 2024 in terms of wellness visits and managing their complex conditions. And so that sets a baseline for us as we move into 2025. And that continuity helps to give us comfort around risk scores and around trends. But Jeff?

Answer – Jeffrey A. Schwaneke: Yeah, just the specifics for Q1, we had 5.5% cost trend on our year two plus markets. And you kind of have to put that in perspective because what we saw was a 1% change from a payer (00:12:00) bidding and 50 basis points from the two-midnight rule, which happened a year earlier. And so really, you're close to that – the way we look at it, you're close to that adjusted kind of 7% cost trend for Q1. And that's really what we've seen in the last two years. So if you look at 2024, roughly around 7%, you look at 2023, roughly around 7% as well. There was a little bit of flu in the quarter and so we had 5.5% versus our full-year cost trend, which is 5.3%. And remember, you just have to do that kind of adjustment in order to kind of normalize and compare to previous years.

Question – Craig Jones: Got it. Okay. Thank you. So Steve, you just mentioned kind of slowing that growth this year. So we've seen them, the cohorts largely in the year two plus this year. So, I think it's important as you intentionally slow your growth to focus more on profitability. Can you remind us sort of where that year one member is from MLR (00:12:54) perspective, how it improves from year one to year two, and maybe how much of a tailwind you've seen or expect to experience this year as you have sort of focus more on profitability?

Answer – Steven J. Sell: Yeah. I mean, I think we've framed this as a transition year all along, moving through a very dynamic period. It's year three of the spread being upside down as Jeff just talked about. And so there's a series of kind of disciplined actions that have been reflected in our plan. And those are things like we exited out of some partnerships and we got the benefit of that in Q1 with – from a payer perspective, we've seen a reduction in Part D and some improvement in terms of the overall economics. We've been able to get additional quality incentives and rolled out more clinical programs. And then the last one is really what you talked about, which is very measured growth. So 2023 and 2024, very large classes, 2025 a much smaller class, 20,000 in comparison to two classes that were north of 100,000 previously. So very conscious decision. But then the second thing that we did is we also changed the underwriting of that first year class. So it's a no downside care management fee that allows us to cover the cost of the programs like burden of illness quality, et cetera and get going. But then the opportunity across a 20-year partnership to bring those members into full risk as the economics improve, the final rate notice obviously puts us in a good direction for that. So long kind of set up on that but typical first year economics for a cohort is between $30 and $60 PMPM. Our breakeven, just to remind you, is somewhere between $35 and $40. If we're below that and don't feel comfortable, we did the care management fee like we talked for the class of 2025. But then across time, that moves to what we believe is kind of that terminal margin, $150 to $200 PMPM. Even in a challenging 2024 and 2025, we're seeing some of our groups at that level. And so with the improvement in 2026 that we expect, we'll get back on that trajectory.

Question – Craig Jones: Okay, great. Yeah. So it's final rate . Obviously, great news for everyone. (00:15:15) on the next. Obviously, this could be a tailwind to margins, no question about that. But when we think about obviously, you have to – it doesn't all fall to the bottom line, because you do is you do pay your physician partners, everything. If we think about – and we don't know when the bid strategy come out. So, excluding that, kind of keeping apples to apples, everything equal, how much of that final rate notice could you potentially see just flow through if bids are relatively stable?

Answer – Steven J. Sell: (00:15:43).

Answer – Jeffrey A. Schwaneke: Yeah. I mean, I think I mean, to your point, holding all things equal, I mean, I think a lot of it would fall to the bottom line. We haven't really given a number yet because, as you said, we're kind of early in the process here with payer bidding. We don't even really know what cost trends are for

2025. But assuming a trend that's been similar to the last few years, again, we believe it's in that tailwind for us in 2026, encapsulating kind of all the things that you just mentioned.

Question – Craig Jones: Okay. Yeah. No, totally makes sense. So, all right. Maybe now, Steve, you made a priority recently, as you have measured growth, more focus on profitability. So to take risk off the table for items you can't control, like you mentioned things like Part D, benefits cards. So Part D, you got to below 30% recently of members. And you still seeing really high costs for the members who are at risk for. So can you first remind us how much has Part D been increasing over the last couple of years? And maybe what you're seeing year-to-date and sort of what you're seeing for 2025.

Answer – Steven J. Sell: So stepping back, the overall goal is to reduce the beta through the transition year a big part of our action plan. Just to remind you, the work we did last year was to take our Part D exposure from roughly 70% of our membership to less than 30% for 2025. The logic around that is our PCPs don't write most of the scripts for Part D, but the bigger issue is we don't have control around the formulary and we don't have control and we don't have visibility to the manufacturer rebates. And that leads to a long tail. It doesn't get settled out until three quarters after the year ends. So for all of those reasons, we wanted to shrink it on top of the IRA coming on board. For that remaining 30%, do you want to give the context...

Answer – Jeffrey A. Schwaneke: Yeah. Yeah. So for the remaining 30% where we retain risk, what we did is we took the losses from 2024 on a PMPM basis and we doubled those because obviously, the IRA increases the amount of risk that's associated with that. And so, substantially, I think mitigating our financial exposure from last year to this year. And then the other thing is just a unique item for us is we record Part D net in revenue, so it's not grossed up. So it doesn't have a sizable impact of our – on our MLR like I think others are struggling to model in the payer space. For us, it's just net in the revenue line.

Question – Craig Jones: Got it. Yeah. I know that is helpful. And so, when you think about maybe taking this 30% to zero, I don't know if it'll be this year, next year, whenever, but say, you're assuming you're able to do it, how big of a tailwind could just eliminating that be as you can you know zero that out from a PMPM perspective?

Answer – Steven J. Sell: I think the biggest benefit of reducing Part D exposure is to narrow the beta. I think that we don't necessarily project a significant pickup in terms of margin year-over-year because we probably trade some Part C...

Question – Craig Jones: Okay.

Answer – Steven J. Sell: ...up for that. But it's worth that as we work our way through it, because what we've found is when we have – are being rewarded for quality and for Part C trend, we do very, very well. It's these uncontrollables that sort of caused some of the volatility around those. And that's why we've been so focused on Part D and in sub-benefit and others.

Question – Craig Jones: Got it. So stability over volatility rather than maybe potential margin expansion. Yeah, makes sense. And then maybe on the benefits cards, I know this isn't quite as big of a issue as it maybe was a couple of years ago. But I think you are trying to eliminate the risk here as well. I think you're still early in the conversations. So, why has it been more difficult, I guess, to eliminate this risk versus the Part D?

Answer – Steven J. Sell: Yeah. Stepping back, we renewed 40% of the book of business for January and we saw a lot of progress. At the top of our list was Part D. Next was quality incentives. We've got $25 million of incremental incentive for 2025. Overall economics and data was kind of number three and number four was supplemental benefit. I think we made progress on all of those. And those are the same priorities as we do the renewal in 2025 for 26% of the January 2026 membership.

And so specifically on supplemental benefit, we did make progress this year. One of the ways that we do it, besides just the negotiation, is the payer bid cycle. So each year, payers submit their bids about this time of the year, and then we have a dialogue with them through the summer into the fall, and then we have the ability to accept or not accept those benefit plans to take risk for them or just not work with them overall. And so that's – as we narrowed some of our payer pipeline, some of that has been reflective of those discussions. But what we found for 1/1/25 is 97% of our membership based on those payer bids saw a step down in terms of exposure to supplemental benefits. So it's on the list. Ultimately, we'd like to carve it or corridor it, but in rank order relative to Part D (00:21:04) that Jeff talked about to quality and overall economics and data, it's number four right now.

Question – Craig Jones: Okay. Makes sense. So let's talk about the incentive plans here or the incentives which are building into the contracting. So it's around achieving certain star ratings. So can you walk us through those conversations with payers? And is this one more of a potential margin tailwind, I would imagine, versus the other two, or maybe more stability? And where are you on a, I guess, penetration of your payer base?

Answer – Steven J. Sell: Yeah. So I mean, good question. I would say quality, real area of strength for us consistently over four – most of our markets had 4.25. And what I would say is one of the biggest changes relative to a couple of years ago is you are seeing almost every payer having this at the very top of their list, or if not number one, it's number two. And I think it's just the world of MA, with the cut points raising and that payer needs to be at four stars. It's kind of table stakes. What they're looking for is their value-based care partners to be at 4.25 or even 4.5 because that has the ability to raise their entire PDP that they're filing above that 4 star threshold. Specifically, your question, the $25 million for this year is in a small subset of payers that we're getting incentives from. We anticipate that number for 2026 growing pretty significantly. And in particular, I think it'll be sort of a ramped model in which if you can get over 4.5, there could be sort of outsized impact on it. We'll update on our Q2 call in August, probably more definitively around the Q3 call in November. But Craig, I appreciate the question because I think it's an area we do well and it's super important to our payers.

Question – Craig Jones: Yeah, absolutely. Yeah. And so I guess like you said, going in 2026, you had 50% up for renewal...

Answer – Steven J. Sell: That's right.

Question – Craig Jones: ...of your members. And I would think the final rate notice would even help you with, I guess, the Part D and the rate cards. And then the incentives should – everyone wants the incentives. I mean, have you started these conversations? It sounds like maybe you're just sort of getting into it, but any color you provide as you go into 2026 with this huge chunk up again?

Answer – Steven J. Sell: It's early, and Jeff is closely involved in these just given his background in the payer world and sort of understanding their priorities and how they think about it. But what I would say is they're very constructive. I think there's a few goals they have. One is to reward us for quality and set the incentives around that. Two is to move more of their senior members into value-based care because of quality, because of cost control, because of the world of V28 that really puts an emphasis on these higher acuity, chronic conditions and the ability to identify those and manage those. So it's early. I think we're encouraged by that. But we'll update as we get to the calls. Anything you'd add on that?

Answer – Jeffrey A. Schwaneke: No, I agree, constructive. Quality is at the top of the list, I think, and that's something we can deliver on. So those are good conversations.

Question – Craig Jones: Okay, great. So maybe moving on to these – you're rolling out some programs, I think, around quality, these palliative care, heart failure, COPD, among others. So first on palliative, I think

you've rolled this out to most of your geographies. Not sure exactly what percentage, but maybe you want to walk us through how this program works, what kind of reception you've gotten from patients and doctors, and how big of a potential impact is it on margins this year and going forward?

Answer – Steven J. Sell: Yeah, so our – going back to this long-term trusted PCP patient relationship, that kind of sits at the heart of everything we do, whether it's chronic condition management or whether, as you just asked about, palliative care, which is advanced illness management. I mean, folks who are identified as most likely being at the end of life. And that's a difficult conversation.

Question – Craig Jones: For sure.

Answer – Steven J. Sell: And so the fact that you have this trusted relationship, the fact that you have the support of a partner who specializes in this area, gives those PCP's much more comfort around that. It's a conversation – multiple conversations with the family and with the patient. Ultimately, there's a decision made to enroll. And part of what we shared on our call last week is we saw a meaningful step-up in terms of the enrollment in that program. We also shared that we've seen a significant reduction in terms of the days per thousand for folks that are enrolled in that program. And I think a big part of it is by getting in front of it, by having an advanced care plan, by having resources that have the ability to go into the home and manage the overall conditions with that patient, it puts you on a glide path that eventually is probably going to end up in hospice, could be hospice at home, could be hospice in the outpatient setting. But all of that leads to a better experience, better quality outcomes. And then the reduction in the hospital days that I talked about.

Question – Craig Jones: Right. Right. And then so maybe to touch again on heart failure and COPD, I think you're much earlier here knowing this output, hopefully very promising, similar to palliative. Can you walk us through again exactly what these programs are? How the doctors, patients are receiving it? And is it similar in margin sort of to the palliative one or anything – maybe it's too early, but anything to call out around potential impact.

Answer – Steven J. Sell: Yes. So the majority of our spend sits with multi-chronic patients. I mean, that's just true in healthcare in general. And so the idea of focusing around those biggest conditions that drive the majority of ER and in-patient spend is the idea behind this. Congestive heart failure is that one that we've rolled out and we've got that in the majority of our markets now. But it's very early days, to your point. The idea is, can this primary care physician identify congestive heart failure earlier in the office, whether it's an in-office diagnostic using the blood test, having the patient come back versus having it be identified later when that same patient would crash into the ER or the in-patient setting. And so in the near-term, there is a cost around the diagnostic to it, but you're going to be able to manage that progression, hopefully, alleviate the rise in that disease burden and prevent or at least delay that ER or in-patient setting that's needed around that. And our physicians really align around the concept. This idea of what we started the company around really comes through in that program. I also think, Craig, it aligns with kind of V28 and sort of from a policy perspective where people are trying to focus in the care.

Question – Craig Jones: Sounds like value-based care is sort of at its core, really.

Answer – Steven J. Sell: That's right. Yeah.

Question – Craig Jones: (00:28:15). So I guess any other programs maybe that are potentially you can rollout soon or anything else you want to call out that's...

Answer – Steven J. Sell: Well, I mean, look, it's – we're trying to be really methodical about them, but I mean, the punch list just goes down those big categories, COPD, dementia, cancer. I mean, those areas that really drive the majority of the cost and quality opportunity that's out there. And again, we're going to try and

structure them in a way that you're really taking advantage of the PCP and the care team around them to identify that early.

Question – Craig Jones: Got it. Okay. So maybe we shift now to your data and forecasting programs, which you've – been a lot of investment in the last couple of years. So, I think you'd agree that one thing Agilon struggled with maybe a couple of years ago was this forecasting medical cost trend. But you put a lot of investment into it. So you're just launching new programs in the first quarter to try to achieve some better foresight forecasting. Can you give us some details on exactly how these programs work? What's your data visibility now versus, say, a couple of years ago? And yeah, just any color there would be great.

Answer – Steven J. Sell: I mean, I – go ahead, Jeff.

Answer – Jeffrey A. Schwaneke: Yeah. Yeah. A couple of things. It's a journey. So we've been talking about the financial data pipeline for over a year. And we finally went live on that at the end of this first quarter. And it was a significant step forward for us. I mean, we completely changed our reserving process for claims based on data from the new financial data pipeline, which is something we haven't had before. The data pipeline has member level revenue details. So bifurcation of revenue down to risk score and claim line information. So similar to the data that a payer would have. Historically, we were using statements from a payer that didn't have that much granularity. So happy to have that information on a going forward basis. But went live in Q1, which is good. Now, not all of our payers are on that pipeline. There's still more work to be done. We're rolling some more payers on in Q2, some more in Q3. So it's a rollout phase. But in this quarter, we had some development from older data service. The financial data pipeline would solve that.

Question – Craig Jones: Okay.

Answer – Jeffrey A. Schwaneke: So, on a going forward basis, we have better visibility into the longer piece of the tail on claims. So excited to be at this point in time, still have more work to do, but we're definitely heading in the right direction, as Steve kind of mentioned before, to just, reduce variability in the business and ultimately help our forecasting process.

Answer – Steven J. Sell: We have further to go on that, Craig. I mean, 85% of the membership in that today, more payers to be added in Q2, more payers to be added in Q3, so that will progress throughout the year. And if you think about the action plan I talked about, but also the guidance, it's sort of been reflective of where we're at from an environment perspective, but also where we're at in this visibility. And so it's been designed to sort of incorporate some of that volatility. And I think you saw that in Q1 even with some PYD, the ability to hit the number.

Question – Craig Jones: Yeah, absolutely. So can you talk about sort of maybe where, if we look at PPD (00:31:22), it's always such a pain. But if you look back now, the data programs are in place. Maybe let's say you closed – you just closed the first quarter, how long until now with this new program will you say we got it, it's done, nothing more to share versus prior to this, how long will it take to close the quarter?

Answer – Jeffrey A. Schwaneke: Yeah, I would say a couple of things. I would bifurcate that a little bit for payers where we had very good data, the data pipeline just provides bifurcated detail, meaning there's really no acceleration of information. But a lot of payers who were, I would say, more delayed in providing us data, there is an acceleration. So we will have more data than we had before and it's at a much more granular level. And so I guess what I would say is for the longer dates of service, it eliminates that tail. We'll be able to see those claims as they're paid versus waiting for statements that may take up to a year. So that's good news. But we still will be on a little bit of a data delay from the payers, maybe one and a half to two months. We'll still have some of that delay, but we'll eliminate some of the longer dated stuff that's come back to bite us.

Question – Craig Jones: Okay. Yeah. It's great to hear. All right. So maybe talk now on risk sharing. So for the first time this year I think going all-in, we're doing a glide path to risk. So when you first roll this out, this idea with the new partners, what was the reception, what's their expectation on maybe speed before risk? And is there likelihood for a middle ground next year or partial risk or kind of how do you see this new idea playing out?

Answer – Steven J. Sell: Yeah, look, I think, again, back to an action plan that reduces beta for this year, given the environment and given the upside outspread that Jeff talked about, when you looked at the economics with these payers, you weren't going to be able to negotiate a percentage of premium rate that was high enough to reflect that. And so instead, we did this no downside care management fee approach that gives certainty around that, allows us to get going. But it does sort of put 20,000 members in the on-deck circle to move into full risk. And we're in a 20 year partnership. So year one of this, do you move all of them in 2026 or the vast majority of them? We'll update as we go through the year, but certainly the final notice helps an awful lot around that. I mean, I think the reaction of the partners was they're getting incentives, they're doing the work and they're looking at a pro forma that says, depending upon what happens with final notice in the things we control, like quality and risk adjustment, here's what this could look like and here's what the distribution could look like. Those economics are much more advantageous than what they're seeing today in the fee-for-service world, or frankly, relative to other alternatives out there. So I think there's good reception. You didn't ask this, but class of 2026 is 30,000 to 45,000, again being measured around that, doing this full implementation. So we make sure we're doing the work in 2025 to bring them on board in 2026 and probably wait some more towards – within existing geographies just because the beta is lower on that.

Question – Craig Jones: Got it. Okay. So as you – you're now sort of negotiating on different parts of the risk side, I think right now, with all of your partners, you're currently splitting the profits 50-50 with no downside risk. Is that right?

Answer – Steven J. Sell: Right.

Question – Craig Jones: And then as you have added this new glide path, the glide path then, are you considering maybe adjusting that no downside risk to maybe a claw back or if they're underperforming, like any adjustments maybe to how you're thinking about that, the no downside split at all or the 50-50 split?

Answer – Steven J. Sell: No. I mean, I think we're continuing with that. I think the big thing is to drive improved performance, to reduce that variability. And the final notice is a big part of that (00:35:11).

Answer – Jeffrey A. Schwaneke: Yeah, no, I don't think there's anything we're considering changing. I mean, just a finer point on that. I mean, they do have to kind of get their way out of it. It's not like those are...

Question – Craig Jones: Okay.

Answer – Jeffrey A. Schwaneke: Yeah. So it's a little...

Question – Craig Jones: So, there is some kind of claw back...

Answer – Jeffrey A. Schwaneke: Yeah, yeah.

Question – Craig Jones: ...or something where it's not just if you do horribly a flip (00:35:29). Okay. Well, that's good to know. Okay. All right. So maybe switch to ACO REACH. We've got a few minutes left here.

Answer – Steven J. Sell: Yeah.

Question – Craig Jones: CMMI you mentioned is great news yesterday.

Answer – Steven J. Sell: Yeah.

Question – Craig Jones: So why don't you walk through the details there, what you've heard, and let's start with that.

Answer – Steven J. Sell: Well, I guess I'd just start by saying ACO REACH has really been a success story for us.

Question – Craig Jones: For sure.

Answer – Steven J. Sell: It's the only full risk program in the Medicare Fee-for-Service program overall. I think it's the easiest data point to look at Agilon's partnership model and say how does it work and that it's effective. And in that program, you are rewarded for beating the cost benchmark. And what happens is in year, your revenue gets adjusted relative to that benchmark and you get rewarded if you're beating that and you're delivering on quality. And so in the most recent reported period, we beat the benchmark or we generate 13% of savings. It's like $150 million of gross savings overall. So really encouraging. That program is scheduled to be up at the end of 2026. It's an innovation center pilot. And so we've been lobbying hard to see the expansion of that, given the outcomes that we're seeing. And just yesterday, I mean, I was just saying this in a way in, CMMI had a webinar, Abe Sutton, the new Head of CMMI, talked about a few things. But one is he said, hey, our new strategy is going to focus on evidence-based prevention for chronic diseases.

Sounds kind of like what we talked about, right? We're going to mandate alternative payment models with downside risk, ACO REACH, the only one in Medicare Fee-for-Service. We are going to expand and replicate ACO REACH and programs like it, that we think is good news. And they're looking for those programs that have the greatest promise around savings and quality. So I think for us, that's a big step forward. Now, devil's still in the details, high level strategy discussion around that, but an encouraging data point for us.

Question – Craig Jones: Yeah, absolutely. I mean, ACO REACH has been the bright spot for Agilon's I'd say in the last – since you went public really.

Answer – Steven J. Sell: Yeah.

Question – Craig Jones: And you've done a great job there. So maybe as we kind of close this out, we've got about a minute left, longer term vision. So Agilon's changed pretty dramatically over the last couple of years as you implemented all of these data, quality programs, everything. First of all, what would you say is the biggest changes now and then? But then looking forward, I guess, a few years from now, how do you – what do you think we'll look back and say, wow, this is – these are the biggest differences, the best change about Agilon that we see?

Answer – Steven J. Sell: I think it's all the things that we've talked about. I think it's going to build on strength of this long-term patient PCP relationship. I think it's going to focus on investing in the clinical areas and these chronic conditions from identification all the way through the management around that. I think it's going to be for us being very disciplined about where and how we grow. But as the macro corrects and as we execute tapping into that demand which is out there. And so I think those adjustments we feel good about kind of what we've done and set us up well for the future.

Okay, great. Well, (00:38:53). Thank you so much, Steve and Jeff.

Thank you. Appreciate it.

Thank you, Craig. Appreciate it.

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