Bernstein Strategic Decisions Conference - Fireside Chat ***(Corrected version)***

Event Details

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Company: Agilon Health, Inc.
Ticker: AGL-US

Company Participants

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

Other Participants

Lance Wilkes - Analyst

MANAGEMENT DISCUSSION SECTION

Lance Wilkes

Hi, everybody. We're at our last event of the day. Appreciate everybody coming in for this one. We probably have a few more people who are maybe getting a drink first and then coming in. But we're looking forward to this.

So, we've got Agilon. Again, let me just start off, especially for anybody online or anything. Lance Wilkes, I'm the healthcare services analyst for Bernstein. Really excited to have the Agilon team here. Actually, I think it was about two years ago that, Steve, you came to our Disruptor Conference.

Steven J. Sell

Yeah.

Lance Wilkes

And so that was a great kind of kick off to the beginning of the introduction – of the relationship, and Amir has been really driving a lot of work on this name as well.

So, we're going to kick things off. Maybe for the audience and for everyone tuned in. Maybe we can just start-off with a little bit of introduction, yourself...

Steven J. Sell

Yeah.

Lance Wilkes

...the firm, and then we can kind of get into just a chat around the big topics that are hitting the market – or the sector now.

Steven J. Sell

Yeah. No. Well, Lance, first of all, thanks for having Jeff and I here today. We're happy to do it. Look forward to the conversation. So, Agilon, the company founded in 2016, really built around the idea that the primary care physician is the best positioned in the healthcare marketplace to manage total cost and quality. But they simply didn't have a business model to make that happen. And so, we've built kind of a unique, long-term, 20-year partnership with skilled medical groups in communities with their primary care physicians, who have longstanding 10-plus year relationships with their senior patients. And what we do is we go to these communities and we move these doctors in these groups, their patients and the health plans from a fee-for-service incentive or compensation model to a budget-based or risk-based model.

And through that partnership and the long-term relationship and the platform that we do that really supports that move to value-based care, we've been able to really scale the company, 2,200 primary care doctors, 30-plus partnerships, 12 states and 600,000-plus senior patients and driven really kind of best-in-class quality and cost outcomes in terms of beating local benchmarks by 20% to 30%, and performing best-in-class, and quality.

QUESTION AND ANSWER SECTION

Analyst: Lance Wilkes

Question – Lance Wilkes: That's great. So, there's a host of questions that are going on right now related – and kind of big picture questions related to Medicare Advantage market, related to value-based care. Thought we kind of start off with some of the more fundamental things and walk through a little bit of – kind of how you look at the value-based care market, how you deliver a value proposition, et cetera. And then move – maybe pivot over to your turnaround plan or the execution you've been sort of kind of going through.

So, to start off with – maybe you can just kind of lay out for everybody, what are the most important ways in which you're driving value for the key stakeholders here, whether the physician partners, whether the plans and obviously for the patients?

Answer – Steven J. Sell: Yeah. So, I mean, whenever we talk about value creation, we always start with this trusted PCP patient relationship. So, been there for a long time, seeing these patients across a long time and with them at the center of everything we do and a platform that really focuses around the ABCs of value-based care, we're able to deliver quality scores. So, in the Medicare Advantage program, on a five-scale scoring above four stars, you get a 5% bonus.

All of our year two-plus markets run 4.25 or better, and increasingly with cut points going up, quality is a real differentiator. And so, we are just saying before we hopped up here, we have payers reaching out to us in a more proactive way than we've ever seen. And they're saying, Hey, look, Agilon, if you could do 4.5 stars, and our value-based care partners could do that, you could literally lift our entire network above 4 stars. So, quality is really a big one that we think about.

Cost being able to be the benchmark at locally. So, the Medicare fee-for-service population, being able to reduce ER and inpatient utilization by 20% to 30% as we've been able to do is really a key driver for us in

terms of driving value. ACO REACH is probably the best example of that. We operate in two programs MA and ACO REACH most recent published results there about $150 million of savings, 13% gross savings rate and it's really around those two things, cost and quality. And so, when you put that all together, you're able to drive a medical margin, which is the revenue you're receiving, plus the total medical costs. And we split that 50/50 with those physicians.

And so, what you're able to do is really change that economic model they started with. So that business model that wasn't working in primary care suddenly starts to work. You're able to reinvest in clinical programs. Other physicians decide to join you and so that's how we've been able to scale this in a really meaningful way. Quality and cost important to CMS. It's really important to payers as we talked about. Obviously, it's important to the physicians. And so, the outcome for the patient, the physician, the health plan is really positive.

Question – Lance Wilkes: That's great. One thing just kind of at sort of global level, as we've talked about value-based care and we're in obviously, at least in my impression, very early stages of adoption, more so in the MA market, but still early innings. Do you see changes in the characteristics or you were just mentioning the magnitude of payer involvement in discussions with you? And I guess, part of where I'm going with this is do you have a view that maybe there's a tipping point when you're like within a market of either within a practice, changing behaviors or within a market, the need for adoption of value-based care in order to keep up. And how close are we to getting to a tipping point, something like that?

Answer – Steven J. Sell: Yeah. I mean, we've been talking about the move to value-based care for a long-time.

Question – Lance Wilkes: Yeah.

Answer – Steven J. Sell: I grew up in Southern California where it's steeped, Kaiser kind of plowed the road 50-plus years ago and that entire market has moved. I mean, the fee-for-service is not very prominent in that market. So, I think there is a tipping point. Our philosophy was we went to markets that were not deep in risk. We were teaching payers, we're teaching groups to make that move and getting critical mass with a skilled primary care physician group who has 20%, 25%, 30% of the senior population and an equivalent amount of PCPs seem to be that sort of critical place.

I think we're coming through year three of a really challenging macro environment, and so that's made it kind of choppy. But what's interesting, Lance, is the demand among physician groups for the move to value continues to be very strong. But among payers, it's really strong. I mean, it's what I said earlier about people realizing given the macro and the policy terms out there around quality, around audits that really require pristine capture of diagnostics and reinforce the PCP patient relationship. I think that's what's going to drive this as we go forward.

And so, I think payers are pushing hard around it. I think physicians are extremely interested in it for all the reasons I talked about because fee-for-service continues to be just not a great option. But this volatility in the market has probably – certainly, we've paused our growth. We had classes in 2023 and 2024, 100,000 senior patients came in, 2025 is 20,000. For 2026, we've said 30,000 to 45,000. But we're being very measured given the macro that's out there.

Question – Lance Wilkes: Yeah. No, it makes a ton of sense. And to me, it would seem that the reaction that you all are taking, which is a really logical and thoughtful reaction to that, might be – is driven by the funding environment, the pressures on margins and return for the business. I would – like I'd be interested in your thoughts as to I would think that the current environment from a payer perspective, the need for value-based

care is actually higher than it is -- than it was three years ago. When you think of rates, they obviously into nice rate (09:14) next year. But in a low rate environment, in an environment where star scores and cut points keep moving up, what's your sense as far as the engagement level there is?

Answer – Steven J. Sell: The conversations are different. There's an intensity to it. The entire senior team is around the table, so this is clearly a priority in the boardroom for payers and among their senior teams. I think it's the macro things that we talked about. But I also think that we've had a lot of frank conversations about we've taken some pain based on some payer decisions in the past and we're working really hard to be rewarded for the things we can control and carve out or mitigate those things that we can't control. That has sort of – this is a 18-month running conversation that we're into and we're coming up on a big bid cycle, right, for 2026.

The frequency of that, the ability for us to look at all these bids as we move to the fall, Jeff's got a team that scores all of those, and us being really honest about if this doesn't work for us, we're not going to be able to take risk around a particular product or maybe with a payer in a market. And last year we shrunk our payer footprint by 10% as a result of that. So, I think there aren't that many full risk value-based care partners that are able to do this at scale. And so, we think despite the environment, we're in a good position in terms of where the puck is going.

So, anything you'd add Jeff?

Answer – Jeffrey A. Schwaneke: No. I think, again, it goes back to the value that we're providing for the payer, which is cost savings, higher quality. And I think, as Steve said, the demand's there and the conversations have been obviously at that senior level and supportive.

Question – Lance Wilkes: Yeah. So, let me hit one of the other topics, it's front page for everybody right now which is just risk adjustment and maybe we will flow right into kind of the current environment utilization and whatnot because you got top line and medical cost there. From a risk adjustment standpoint, could you talk a little bit about your risk adjustment process, how you go about it, maybe kind of the credibility that is within that process? And then think about the 2028, what are the implications? What have been the impacts of that to you? And then maybe how have the results differed from what your expectations were there?

Answer – Steven J. Sell: Yeah. I mean, there's a lot in that question.

Question – Lance Wilkes: Yeah.

Answer – Steven J. Sell: So – and Jeff is so well-versed in this, so you should chime in. But, I mean, it always starts with the strength of the PCP patient relationship. And I think if I step back and look at V28 and RADV audits, I think it's pushing the world towards that and the importance of it. Philosophically, risk adjustment or as we call it our Burden of Illness program, is sort of the foundation of our clinical model. And the early assessment and diagnosis is then managed is matched up with care plans to manage really chronic diseases and ultimately prevent or delay the progression of the disease and people unnecessarily ending up in the inpatient or ER setting.

So, it's – we call it our BOI as a clinical program. It's really at the heart of everything we do. So that philosophy kind of permeates everything we do. I think as we look at V28, when it's done, we think it's a more clinical world. And so, if you look at the policy logic, I think it's to say the largest chronic diseases that are driving the majority of inpatient ER utilization, congestive heart failure, COPD, dementia, cancer, those are the things that

we want primary care physicians identifying and preventing people from an acute event in the ER inpatient setting.

And so that – that's a big part of what we do in our Burden of Illness program, the RADV audits, as you expand those audits out, again, I think it pushes towards reinforcing. People have a really pristine process around that. So, we have 100% chart review process. We have a clinical – pure medical record review process. We have a process that requires suspected conditions to be matched with data and evidence around that. All of that, I think, is where the world is intended to go and what people are trying to structure around that.

So, I think for us, we believe, again, the risk adjustment world is kind of moving towards what we do and we'll reinforce that there are big changes, right? So, V28 running, this is the third year now, side-by-side V24, V28 there's a lot of logistics and operations within that. The headwind that you have to come over this year, it's a net 2% increase in risk adjustment that's overcoming probably a 3% headwind. So, call it a gross 5% to get to a net 2%, that's a lot. And running those two side-by-side was maybe a little bit more complicated than we realized. But now you're – it's 100%, you're here. It's all that you're focused on and really getting those appropriate diagnoses and thinking about it as a clinical program is kind of the heart. But, Jeff?

Answer – Jeffrey A. Schwaneke: Yeah. I think another factor is just where you started from. We were coded at roughly the nationwide MA average. And so, I think for those that were at higher coding efficiency, I think the transition to V28 was a little more painful. We were right around the market average and as Steve – I think Steve mentioned a net 2% in 2024. So, gross 5%, net 2%, assuming the same thing here for 2025. And then, of course, next year is the last year of the season (15:35). So...

Question – Lance Wilkes: Yeah. Are you observing – one of the things that's been big from a competitor or another payer's commentary from the last couple of weeks has been sort of a miscalculation or a different outcomes coming from the V28 implications – impacts as opposed to what they'd expected going into for 2025 with respect to like a decent population, have you seen anything in your world like that?

Answer – Steven J. Sell: Yeah. I mean it's, I guess, what I'd say is it's still early for 2025. We're still getting the data in, I would say, for 2024, right. What we did is we said, listen, we think we have a 2% net left in 2024. That's what we put into the guide for 2025. We haven't seen anything at this point that says it's different than that. But again, it's still early.

Question – Lance Wilkes: Got you. And maybe while we're talking about risk adjustment, maybe we can put a little context for everybody around what you've been seeing as far as utilization trends. You got some great charts that you guys do in your quarterly calls or at least reference to. And what you've observed with those trends kind of over the course of 2024 and then what you're seeing thus far in 2025?

Answer – Steven J. Sell: Yeah, sure. I think as you think about utilization, and I'll go back to 2023, I think 2023, roughly 7% cost trend; 2024, roughly 7% cost trend. I think as we thought about 2025, we had 5.3% in the guide. Now, you have to adjust that because of the payer bidding process, there was really 100 basis points of was cost shifting to the member and then you had the two-midnight rule in 2024, which is roughly 50 basis points. So, from our perspective, the way we thought about 2025 is we have a consistent amount of cost trend in the guide. I think if you look at Q1, we came out around 5.5%, full year is 5.3%, still comfortable with that, but that had a little bit of flu in it. And I would say, the drivers exiting 2024 and the drivers in 2025 are very similar, it's inpatient cases in Part B, B as in boy, drugs. And so, it's – I think our commentary, I would say, resembles the broad payer commentary, which is consistent – high, elevated, but consistent exiting 2024.

Question – Lance Wilkes: Got you. And maybe dabbling into the turnaround plan you guys have been executing on, can you talk a little bit about maybe how prior periods and reserves are sort of developing with

that and what some of the changes in your process have been to accelerate kind of your recognition there?

Answer – Steven J. Sell: Yeah. Yeah. So, a big milestone this quarter. Significant step forward for us. We've been working on a financial data pipeline for over a year, and the pipeline provides detailed revenue and claims information down to the member level. So, think about bifurcated premium by member, bifurcated claim line information by member. We haven't had that level of detail before, and so we went live on that at the end of Q1, so at the end of March, complete change to our process. So, the old reserving process has gone, new reserving process here. Now, we're still early, right? We just went live. Not all of our payers are on the financial data pipeline, so we still have more work to do. We're rolling another group of payers in by the end of Q2.

We have some scheduled for Q3 and it's a ramp, it's a journey, it's been a journey. And so, what I would say is we're a lot better from an information perspective and a process perspective than we were before. But we still have more work to do. And part of what we're pushing on with our contracting team is getting more real-time data. We have inpatient census data from our payers that help us with this estimation process. And I would say we're continuing to look at ways to accelerate the information flow between us and the payers and get third-party information in order to inform our estimates.

Question – Lance Wilkes: Got you. One question maybe at a local market level, and this would be informing some of the insights I think you'd have from a utilization – outlook for utilization. What sort of – what's maybe the typical amount of payers you're contracted with in a market? So, you're typically – or the audience you guys have a model where you're not just popping to the clinic and there's a single doc, you've got big established practices, so you've got some market density, but what kind of coverage do you have as far as across payers there?

Answer – Steven J. Sell: Yeah. So we – it goes back to sort of the founding principle of the model is scaled groups in a community and moving physicians, patients and payers into risk. So, three or five (20:38) is sort of the average within a marketplace. Now, given some of the decisions we made for January 1, you might have gone from five to four (20:47) in a market. But you have strong density, you want to have options for payers. And again, we believe the organizing principle is around the PCP relationship. And so, they can move from payor A to payor B, but all of the clinical work, all the quality, all of the assessment work continues with that patient. And so that continuity across time is really important.

Question – Lance Wilkes: Got you. Maybe to tie in with that and just talk a little bit about some of the progress you've made on the turnaround and whatnot. Can you talk a little bit about the recontracting strategies and some of the things you're carving out, progress? We know the progress as of the end of the year. Like any further progress as you're renegotiating towards next year?

Answer – Steven J. Sell: Yeah. I mean, look, we've tried to be really disciplined and the headline is we're trying to improve performance and reduce (21:43). And so, elements within that or we exited out of two partnerships last year and saw improvement from that, we've been very measured from a growth perspective in terms of what we're doing from that standpoint.

And then in terms of payor contracting that you asked about, we focused on a few things. One is reducing our Part D, as in dog, exposure has the challenges that we talked about. We don't have – A, our primary care physicians don't write the majority of the scripts. But the bigger issue is we don't control the formulary and we don't have visibility to the manufacturer rebate and that typically settles the third quarter the following year, it goes to the PBM and the payor and then we get sort of an outcome. And when you're running 30 partnerships, it just allows for massive volatility and in a long tail. So, for all those reasons, we said we want to shrink our Part D exposure. Oh, I forgot, what Jeff always talks about, which is the IRA came on board,

right, for 2025 and dramatically increased the dollars associated with Part D. So, our goal was to shrink that. We had 70% of our membership that we had Part D exposure for in 2024. We shrunk that to 30% of our membership in 2025. It's very early, but it's at the top of our list for 2026. We've already had one payor agree to carve out Part D for 2026, so that number will continue to come down. That's priority one.

Priority two is these quality incentives. We talked about how strong we are, how important it is to payers. Half of our initiatives that are in our plan for this year, there's $50 million worth of initiatives, half of that is quality. Those are from incentives we didn't have a year ago from payers saying it's worth a lot to us, if you're north of 4% and even north of 4.25%. As we go to next year, we believe there's more opportunity around that in focusing, boy, if we can get to 4.5%, it can really be worth a lot to me. So that's number two.

Number three is just overall economics in terms of percentage of premium, and we kind of package with that. We need to make sure we have really quality data that Jeff always talks about. So, it's not just the economics are good, but the predictability and visibility with that.

And then number four is lowest on the list, because it's the smallest dollar amount, is supplemental benefits. And for 2025, we saw 97% of our membership see a meaningful step down in supplemental benefit exposure. I think as we're going through conversations, we believe payers are going to bid very rationally for 2026, but we're going to have an opportunity as we go to the fall to really see all of that.

So, 40% of our membership renewed for 1/1/2025, 50% renews for 1/1/2026. So, there's a lot of opportunity, Lance, just for us to change some of those elements that we talked about. And so far, it seems to be very constructive.

Question – Lance Wilkes: Yeah. It makes a ton of sense there. One of the thing on the turnaround that is real important is improving the cash flow position and the cash position of the company. You talked a little bit about progress you've made there, future steps you still have to get and the like.

Answer – Jeffrey A. Schwaneke: Yeah. Yeah, sure. So, just to set the framing here. At the end of the year, we outperformed our cash flow projections. So, at the end of 2024, end of the year with roughly $440 million of cash on the books. Ultimately said, we're going to burn about $110 million in 2025, I think $37 million of that hit in Q1. So, no real update there. We still think that's the number for this year. And then heading into the goal of being cash flow breakeven by 2027.

Several levers in there that we have to pull and we can pull that are still, I would say, not in that number. One is contracting. And so, we continue to work with our payer partners on getting advanced payments, if you will, on our estimated margin settlements. So, that's in flight now. You have to put that in the priority order that Steve put all these other economic items in. But it's on the list for sure. Two, is really cost control, so focusing on tighter cost management. I mean, those dollars are every month and they're real. So, we definitely have our pencils sharpened on cost control for this year and for 2026.

And last is there are some items in what I call working capital. So, just receivables from vendors and others that we're making an effort to go and collect and clean up, if you will, that could, I would say, add to our performance in 2025 and 2026. So, I would say we feel pretty comfortable that we've got the capital necessary to to get to where we want to go. And there's more work to be done here. But I think there's opportunity for us certainly to improve where we are from where we are today.

Question – Lance Wilkes: Got you. And maybe just tying up the turnaround in utilization. As you're looking at both the things you're controlling and then the streams of data that are coming back to you that are

getting influenced, are you seeing any changes in utilization behavior in your MA populations this year, meaning, are you seeing inpatient step down, outpatient step up? Actually, obviously, one of the things that's out there is, are you seeing like an unusual uptick in physician and outpatient non-surgical? But just in general, obviously, Part D is less exposed there. But there must be an area that's stepping up. But in general, are there any changes from like the 2027 key drivers sort of from a priority order?

Answer – Steven J. Sell: I mean, I think the headline is utilization is sort of in line with our expectations. And from 2024 to 2025, it looks relatively consistent. The big drivers in 2024 and now through the first four months of 2025 is inpatient spend that Jeff just talked about. In Part B is boy (28:10) drug, primarily driven around oncology drugs. So, those continue to be kind of those those biggest places. Part of Q1 was heightened flu for us, but that was kind of true for everybody. And that that affected some inpatient spend. But that was kind of captured within our guidance, so that was sort of consistent with what we've seen.

I think, when we look at outpatient, we look at our physician utilization, it's sort of in line with our expectations, and tracking sort of in line with the overall utilization trends that Jeff talked about. So, that's what I would say. I don't know that we necessarily see big material changes. Like at the end of 2023, it was hips and knees and outpatient surgeries that really surged and that felt like pent-up demand. And coming out (29:02) I don't know that today we see a material change like that.

Question – Lance Wilkes: Sure. Okay. Shifting over to kind of the physician side of this and the opportunity to, both your existing base, how is that operating from their perspective and then the opportunity to add new physician practices? Could you maybe talk a little bit about kind of, to start off with, what are the incentives that you put in place with the physicians, what's the infrastructure you put in place with the practice and the services that you're providing there? And then we can talk a little bit about, okay. And then, what sort of changes are you needing to make in this tough environment, macroenvironment out there, to keep those folks engaged and happy with the partnerships?

Answer – Steven J. Sell: Yeah. Well, I'll just start by saying our Net Promoter Scores from our physicians are 70s and 80s, right? So, even through this challenging environment, our physicians are really engaged. The leadership of these groups are incredibly engaged and saying they've sort of made the leap, they've kind of crossed the chasm, and value-based care is their future. And despite the volatility of the macro that we've been talking about, they need to be successful around it. And so, we spent a lot of time talking about what are the basics that we have to do really, really well. Some of it is around, we call it the ABCs, but the attribution work that we're doing with payers to make sure that we have – the folks that we're seeing, are appropriately taking risk for those folks. But burden of illness and quality, making sure that you are prioritizing and getting those most complex patients identified and in for visits, super important. Making sure that you are touching those most complex patients most readily is incredibly important.

And then the clinical program, so I think we talked about this world of V28, we talked about a bit more (31:07) clinical model. That is where we've doubled down. We've said those chronic diseases are what drive the majority of the spend. We have this incredibly trusted continuity of relationship; and regardless of people moving between payer, we want to continue that.

And so, we talked a lot on our call about congestive heart failure. We talked about advanced illness management through our palliative program. Those are areas where we are very detailed at the market level around how do you get people enrolled into advanced illness management? How do you have those conversations that are hard for a primary care physician, even with someone you have a really trust relationship? But it's multiple conversations, lands with the patient, with the family, to make that decision to ultimately go into palliative. And then ultimately, you're going to make the move into hospice at some point.

And so, it's that last mile. It's really about how does it occur? Who's doing it well? We have the support of a great national partner around that that helps within those critical conditions. So, those are the things that we're really focusing on. And then the incentives are really around how do we make sure that we have these primary care physicians focused on those most critical things? In the early years, it's probably around annual wellness visits, getting those assessments done. But as you move across time, it could be around these high-risk touchpoints, making your seen – making sure you're seeing those most complex patients most often.

Question – Lance Wilkes: Got you. For the practices you're working with, what percent of their patients and what percent of their revenues are kind of comprised in the areas that you're touching those practices?

Answer – Steven J. Sell: So, it varies. I mean, we have many practices in which this is the 35% of their membership. But in terms of the economics of their practice, it's two-thirds or more. We have some in markets where this is 50% of their practice and proportionally even far greater from a revenue and an income perspective. When I said our groups have kind of crossed the chasm and said this is our future and where we're going, I think they've really seen the impact. I mean, just to give you context, you're talking about physicians that maybe have an income of $150,000 to $175,000, and incrementally you could double that...

Question – Lance Wilkes: Yeah.

Answer – Steven J. Sell: ...by doing these things, taking better care of patients. You've got this incredible satisfaction for the physician, how they want to practice medicine, and for the patient. Now, that's moved a little bit with the environment, right? But they've seen sort of what that impact can be. And that's why we're so focused on those initiatives I talked to you about.

Question – Lance Wilkes: Yeah. And just for folks out there, like a couple of things in my experience, that doubling the take home compensation for physicians, that's always – I know we talked about Herb Fritch back when he was launching HealthSpring. And just in my experience as running docs, 2%, 3% quality bonus, you're not going to really change what you're doing. If you're doing 50%, 100%, that obviously really changes what you're doing.

And then the other thing is, I know in like my past dinners with Optum Health and and over the years, one of the challenges that they would have with practices because they have a different model, but still an existing practice model, was if it would be 5% or 15% of the practice that they're kind of impacting with risk, and how do they people engaged, the numbers you're talking about not just on the high end, but the low end, or something that really is consistent with making changes is fascinating.

Could you talk a little bit about as you're looking for kind of growth in practices going forward, what's the sort of stability you're looking for in the firm before you really reinitiate the geographic aspect of it? Obviously, you can put more membership through the existing practices, and that works well.

Answer – Steven J. Sell: Yeah. I mean, we've definitely been very measured in our growth. It's part of our action plan. We've called this a transition year because we understood the macro and kind of where we were at in our own journey. And I think we feel really good about that decision. Part of that is this measured growth. To put in perspective, the class of 2023, class of 2024 were 100,000-plus new members, four to six new partners, most of them in newer geographies.

So, expanding to your point, I think as we went to 2025, we said a couple of things. One is we're going to shrink that down, so the class 2025 is 20,000 members; class of 2026, we've said this is going to be 30,000 to

45,000 members. We also said we were going to grow more through this challenging period in our existing footprint because it's lower beta, it's existing clinical programs, it's existing payer contracts and those things.

I think one other area for growth that is lower beta for us is in the Medicare fee for service world, right? We've got ACO REACH, we've got MSSP in a couple of places. We're only 20% penetrated within our footprint today.

So, the opportunity to expand that across time, I think, is a real opportunity for us. So, we're trying to be measured on it. I know this is very attractive to a number of groups out there. We are just being really tight around pattern recognition and very honest with potential partners. We do a five-year pro forma with them and kind of lay it out. The movement right now around some of the macro things is meaningful. And so, getting clear on that is important. But within your existing footprint, you have a really high recognition and sort of more measured on.

Question – Lance Wilkes: Got you. As a result of the macro environment for physician groups, right now that's not a huge emphasis of, oh, let's just go expand as frequently as we can. But what do you see as maybe the changes in outlook for physician groups going out in the future? Are physician groups more likely to want to stay independent and be enabled or more likely to want to be sold to a hospital? Like how do they look at the world since you talk about...

(37:57)

Answer – Steven J. Sell: We have a number of our groups where their mantra is really in the back of their business card is keep the independents independent. So, fierce entrepreneurs, fiercely independent. It's a fun group to have a network with. And so, I think the majority of the world is not independent...

Question – Lance Wilkes: Yeah.

Answer – Steven J. Sell: ...right? And it's been on a decline. I think, in the markets we've seen, we've been able to stabilize it and start to grow and actually had some people move out of employed practice into independent practice. So, I think that's an opportunity. Having said that, we've got a couple of health system partners. We just had our board meeting last week and at our health – one of our health system partners come and meet with our board, and they're doing amazingly well around these things that we talk about, and the clinical basis of this chronic care management programs really resonates within that in that setting.

And so, I think we see that as an opportunity. I think we've learned through our pattern recognition about how you really take a tight focus on that and validate those key attributes that you're looking for. But I think that's an opportunity as well.

Question – Lance Wilkes: Let me ask you on the fee-for-service types of opportunities, ACO REACH, et cetera. Well, what's sort of the economics and margin opportunity in that sort of a business contrasted with traditional full risk global cap sort of business?

Answer – Steven J. Sell: So, in our partnerships in which we have ACO REACH today, the medical margin in that business is north of $100 PMPM in this environment. And MA, right now, it's at like $50 PMPM below, right? So, long term, we've talked about $150 to $200 for mature markets and getting that above $100. So, that gives you kind of the order of magnitude difference. Now, there's a reason for that though. The gap on revenue and cost that exists within MA and this catch-up that you're playing, ACO REACH corrects within the year. So, that's one big difference.

Two is you get – it's really a cost business. Jeff always says you get rewarded for beating the cost trend at the local level and we've been able to consistently do that. That's the savings that I talked about earlier.

But then the third thing that's interesting about ACO REACH is there's no Part D isn't – yeah, dog. There's no supplemental benefits and there's no payer bidding dynamic. And so, as we've talked about improving performance and reducing beta in MA, look at what we're going down the road on, what our priorities are, because we've demonstrated same docs, same clinical programs, different payer, slightly different rules and program. We do incredibly well in that. And so, that's what gives us confidence within MA as we think about that, but also why we want to expand that Medicare fee-for-service penetration.

Question – Lance Wilkes: Sure. Can we talk a little bit about the J-curve? And maybe if you could frame for us a few years back how you might have looked at a J-curve and maybe how it contrasts with different models. So, obviously a model where you're building the clinic and whatnot is going to have probably more exaggerated profitability increased curve than in your model. But how has that changed today as you've kind of refined the business model? A lot of times I'll try to frame for folks we were talking about like history here, like to me what you're going through now for me, but what maybe HMOs are going through 1985 to 1995, up and down and refining, and then like a period of really interesting growth.

And as you're looking at that refining, I'd be interested in maybe what a J-curve is going to look like in the future?

Answer – Steven J. Sell: Yeah. I mean, you should jump in on this, Jeff. But I mean, look, we've learned a lot. And I think the action plan that we talked about is intended to improve that performance and the margin progression that you're asking about. I mean, I guess just one distinction I would make is we're a capital-light model, right? We're doing the partnership with groups that have been there for long terms. So, there's not that initial couple of years of where you're running big losses around it. Typically our year one is breakeven plus or minus.

We talked about a range of $30 to $60 PMPM. 2025 was so challenging from the spread being upside down that we, for the first time, did that no downside care management fee contracts. But that's one year and a 20-year partnership. And the goal is to make them move to risk as quickly as the economics make that possible. The final rate notice for 2026 was a really good start on that. So, that's the idea. But then you progress up from there.

You want to pick up, Jeff?

Answer – Jeffrey A. Schwaneke: Yeah, yeah. I mean, I guess what I'd say is our views on the long-term margin haven't changed. And Steve mentioned this earlier, $150 PMPM to $200 PMPM on a medical margin basis. Yes, we're operating in this challenging macro environment. So, as the J-curve been bumpy, yes, but ultimately we still think it goes up into the right into that $150 PMPM to $200 PMPM. And I think we mentioned this earlier, I mean, we have groups even in this challenging macro environment that are

performing in that range today. And actually in groups that aren't in that $150 PMPM to $200 PMPM, there's individual docs that are.

And this is in a challenging macro backdrop. And so, I think as we think about 2026, 2027 and obviously the rate notices is helpful. Net positive tailwinds, we think, heading into 2026 to get us back on the curve trajectory, if you will.

Question – Lance Wilkes: Yeah. Last question I've got here is, as you're looking at enhancing and further improving your overall cost control and outcomes and in looking at areas like specialty cost containment areas, palliative you mentioned, could you talk about what you see as maybe some of the most important opportunities for that and magnitudes of difference that those sort of opportunities could make for you?

Answer – Steven J. Sell: Yeah. I mean...

Question – Lance Wilkes: (44:39).

Answer – Steven J. Sell: Yeah. No, no. Yeah. So, just like all throughout healthcare, the majority of our costs sit with the multi-chronics, right? So, you think about that pyramid as you move up, the costs get greater. And so, the focus of our program is around managing those multi-chronics and ultimately managing really well through the end of life. Congestive heart failure is a significant cost area, for COPD, dementia. People with poor chronic conditions drive like 65% 70% of our costs. And so, the idea around these programs is we're going to spend money early to identify them and manage that across time, and it's going to show up coupled with things like high-risk touchpoints and fewer people on inpatient setting and readmission rates dropping pretty significantly.

And we've been able to see some real meaningful impacts in some of our programs, significant reductions in readmission rates that are material from low double digits to the high single digits. So, those are in each point on readmission is worth a lot. So, I think inpatient is a big cost category for us of impact. All of our programs are going to to impact that, and then end of life is just a massive area. And we've seen an increase in enrollment. We've seen a reduction in our inpatient days per thousand and hospital-based deaths.

So, anything you'd add there?

Answer – Jeffrey A. Schwaneke: Yeah. No, I think oncology is an opportunity for us as well. So, more focus and rigor around that that we're applying. I mean, I think, as Steve mentioned, we just go across the cost categories and have a clinical program matched up to it, and that's what we've been focused on.

Perfect. Well, really appreciate you taking the time with us today. Hopefully, it's been a useful day for you. Thanks, everybody, for coming to this. And I think that's just about the end of our day one of Strategic Decisions Conference. I believe there might even be drinks out there somewhere. So, I hope everybody has a great day. Thanks a lot.

All right. Thanks.

Thanks, Lance.

Thank you, guys. Really appreciate it.

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