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Driving Performance At Scale: The agilon Framework

Technology-Enabled Clinical and Quality Programs to Advance Patient Outcomes

November 17, 2026



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Statements in this presentation that are not historical factual statements are "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements include, among other things, statements regarding our and our officers' intent, belief or expectation as identified by the use of words such as "believes," "expects," "may," "will," "shall," "should," "would," "could," "seeks," "aims," "projects," "is optimistic," "intends," "plans," "estimates," "anticipates" or the negative versions of these words or other comparable terms. Examples of forward-looking statements include, among other things: statements regarding our expectations related to our strategic plan and its benefits, our growth trajectory, expected revenue, medical costs, net income, total and average membership, Adjusted EBITDA, medical services expense ratio, geography entry costs and other financial projections and assumptions, including our fourth quarter of fiscal year 2026 and full-year 2026 guidance. Forward-looking statements reflect our current expectations and views about future events and are subject to risks and uncertainties that could significantly affect our future financial condition and results of operations. While forward-looking statements reflect our good faith belief and assumptions we believe to be reasonable based upon current information, we can give no assurance that our expectations or forecasts will be attained. 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Additionally, ongoing implementation of performance initiatives, leadership changes, and dynamic market conditions create additional uncertainty regarding our future operating and financial performance. Except as required by law, we do not undertake, and hereby disclaim, any obligation to update any forward-looking statements, which speak only as of the date on which they are made.

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Today's speakers



Dr. Karthik Rao
Chief Medical Officer



Varun Anand
Senior Vice President, Product & Interim Chief Technology Officer



Dr. Jon Copeland
Family Physician, United Physicians



Heidi Hittner
Chief Business Operations Officer

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Agenda

1. **Total Care Model and clinical care** – *Dr. Karthik Rao*
2. **Focus areas**
    a. Technology foundation – *Varun Anand*
    b. Clinical pathways – *Dr. Karthik Rao*
    c. Physician engagement – *Dr. Jon Copeland*
    d. Quality programs – *Heidi Hittner & Dr. Jon Copeland*
3. **Q&A**

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Total Care Model and clinical care



Dr. Karthik Rao
Chief Medical Officer, *agilon health*

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Scaled VBC partner driving primary care physician success

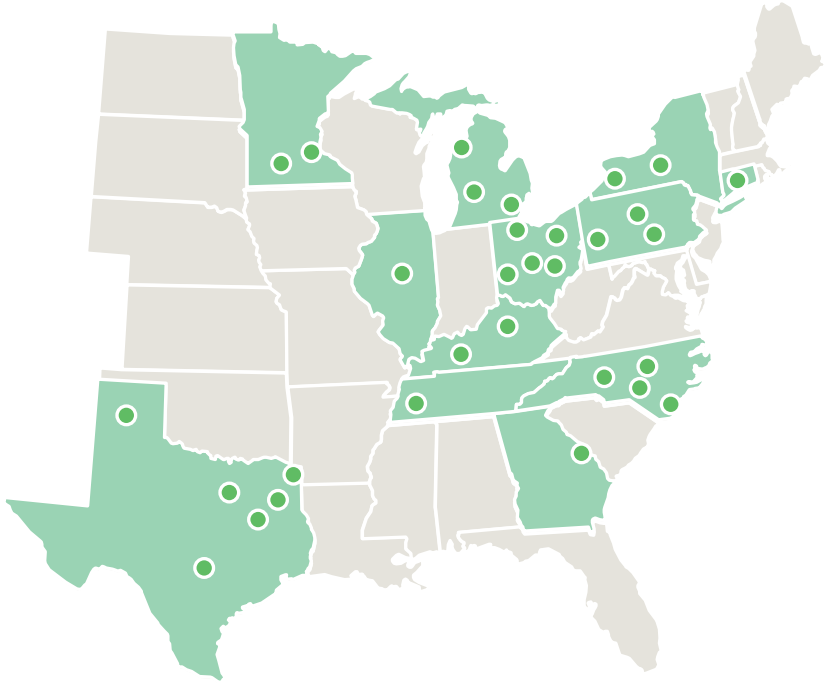
~30
Markets Nationwide[1]

~2,200
Primary Care Physicians[1]

500K+
Medicare Patients[1]

~$6B
Total Medical Expense Managed[1]

- **Deep, embedded relationships with physician partners**
- **Scalable capabilities across markets and conditions**
- **Improving health outcomes and patient experiences**
- **Sustainable growth and shared financial value**



Note[1] Metrics as of December 31, 2025. Medicare Patients include both Medicare Advantage and ACO-attributed members on the agilon platform.

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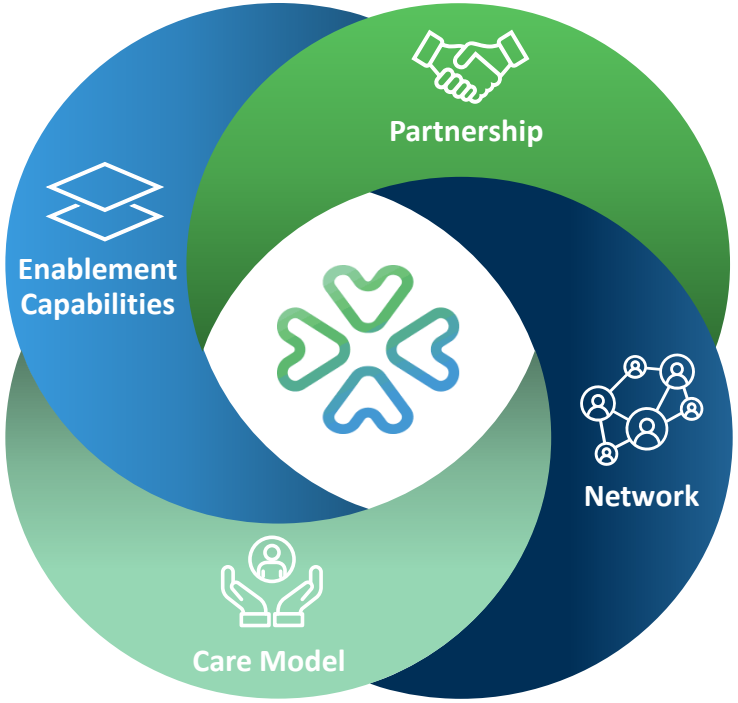
agilon health Total Care Model

Four integrated capabilities, one physician-led model



Partnership

agilon works side-by-side with local primary care physicians to transform their practices to improve care for Medicare patients.

Network

PCPs from across the Network to actively engage with each other to share best practices and identify ways to get better, faster, together.

Care model

agilon delivers a structured end-to-end approach to managing chronic conditions in the primary care setting. Timely insights and coordination with the local care delivery system help keep patients healthier and support appropriate management of overall costs.

Enablement capabilities

Technology, data and AI combine patient health information from separate systems into a single source, giving physicians a comprehensive view to manage their patients' overall care.



Empowering physicians to help their patients live healthier lives

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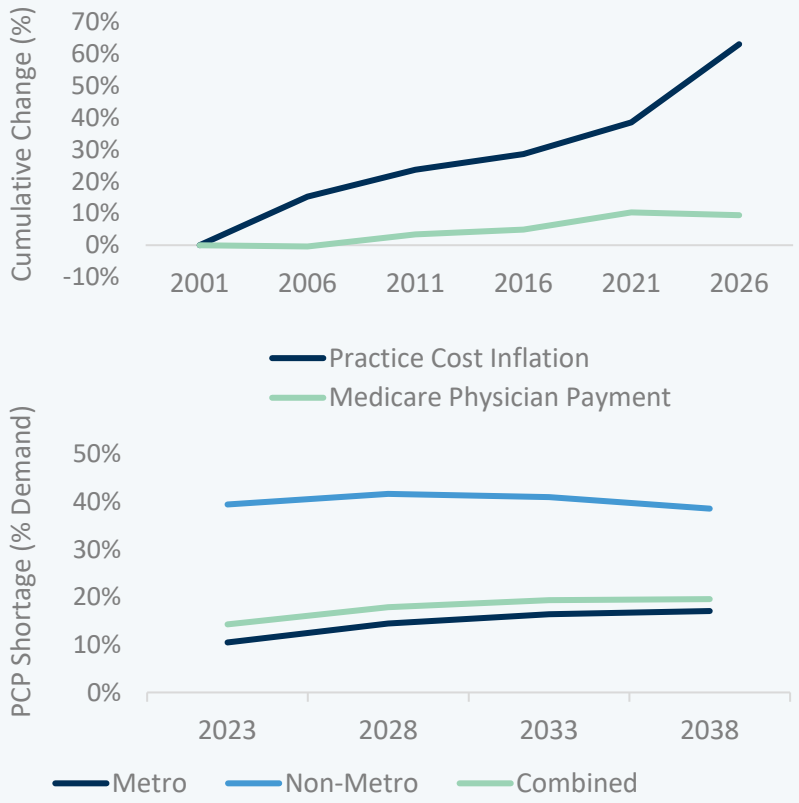
The problem we solve

Primary care physicians face mounting strain as multiple chronic conditions also drive most of Medicare spend

Increasing Strain on Physicians



Physicians have seen a **~33% decline in real Medicare reimbursement** since 2001.[1]

20% national PCP shortage by 2038. Double that, **~40%, in non-metro communities**.[2]

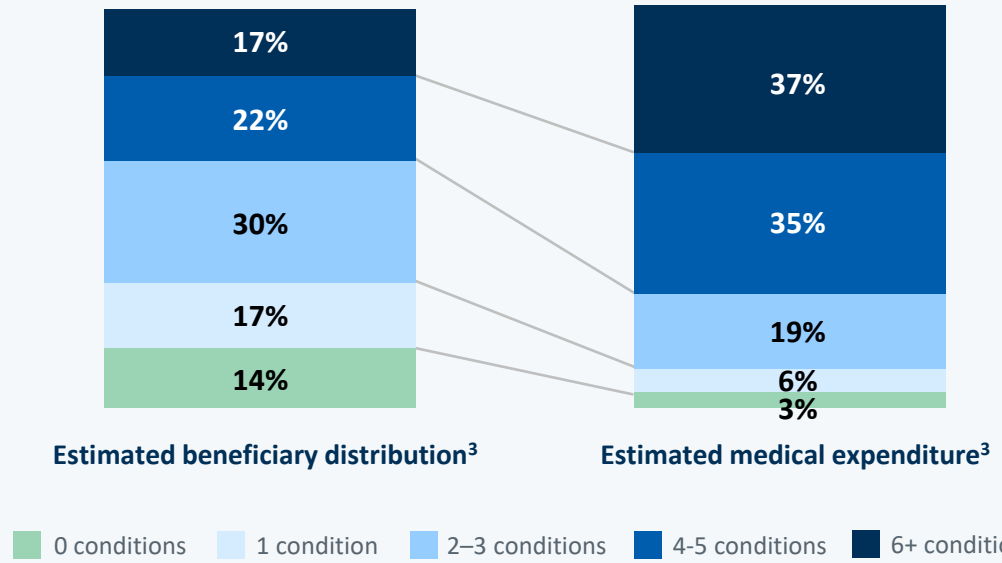
Increasing Spend with Complexity

39%

Estimated Medicare beneficiaries with 4+ chronic conditions[3]

~$800B

Estimated Medicare spend on individuals with 4+ chronic conditions[3,4]



Note[1] American Medical Association, "Medicare Physician Updates Compared to Inflation in Practice Costs (2001–2026)," January 2026, based on Federal Register, Medicare Trustees' Reports, and CMS data. Cumulative change since 2001; inflation measured by the Medicare Economic Index (MEI). Figures approximate. Note[2] U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), "Health Workforce Projections: All Primary Care Physicians (2023–2038)," accessed October 2026. Shortage calculated as (demand − supply) ÷ demand, in full-time equivalents (FTEs); 2038 projections. Figures approximate. Note[3] CMS OMH, Mapping Medicare Disparities Tool, 2023 Medicare FFS data; CMS Chronic Conditions Chartbook, 2012 Edition (2010 data). Expenditure distribution is an agilon estimate based on 2010 cost and 2023 prevalence data. Note[4] CDC, Fast Facts: Health and Economic Costs of Chronic Conditions, 2026 (based on RAND, *Multiple Chronic Conditions in the United States*, 2017).

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agilon health clinical model

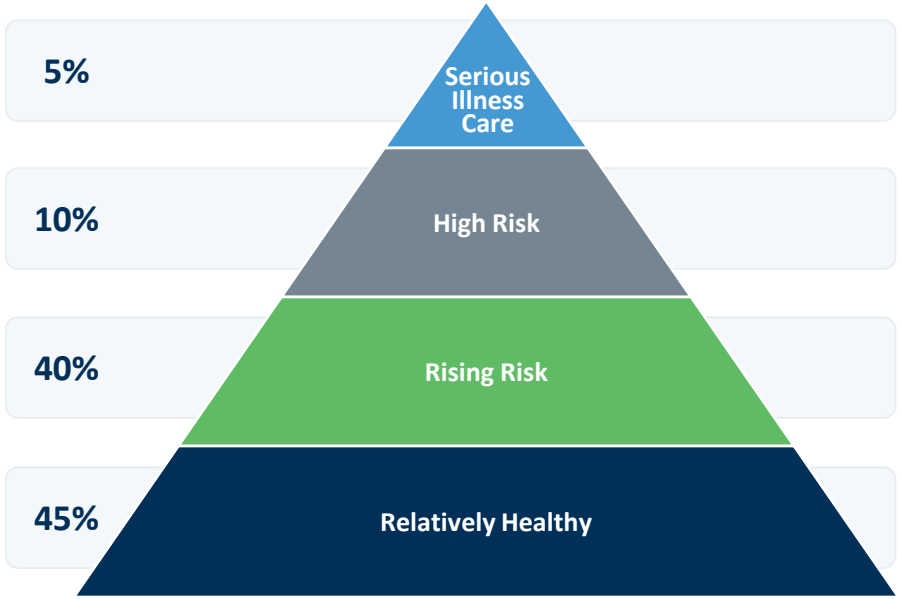
BURDEN OF ILLNESS[2]

Appropriate and accurate diagnosis

- ✓ **Chronic condition reassessment**
- ✓ **New condition assessment**
- ✓ **Proactive condition identification**

Most appropriate treatment + Access priority + Risk stratification

% Seniors in risk stratification category based on avoidable utilization[1]



CLINICAL INTERVENTIONS

Comprehensive high-risk care

Palliative and hospice

Care team touchpoints

House calls and high-risk focused clinics

Clinical pathways

Priority chronic conditions

- Heart failure
- Dementia
- Lung health
- Kidney disease
- Diabetes

Fundamentals of value

Care coordination across care episodes

- Transitions of care
- Post-acute care

Annual wellness visits

Quality measure-directed screenings

Physician engagement - Through daily point-of-care interactions, actionable performance reporting, and quarterly active panel management — reinforced through aligned physician engagement focused on care quality

Technology platform - Deep data paired with point-of-care actions and operational insights to improve care, quality, and cost

Note[1] Risk stratification pyramid is a conceptual model commonly used in population health management; percentages do not represent agilon patient data. Note[2] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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Focus area:
Technology foundation



Varun Anand
Senior Vice President, Product &
Interim Chief Technology Officer, *agilon health*

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Technology drives insights across the network

DATA PRODUCTS

The agilon data ecosystem

Financial Data Pipeline
30-60 DAY CLAIMS LAG

- Membership
- Payor Census
- Premium & Statement
- Claims

Operational & Clinical Data
~REAL-TIME

- EMR Integration
- HIEs[1]
- Referrals
- Scheduling & Billing
- Real-Time ADT
- Labs
- Quality Gap Reports

INTELLIGENCE

Analytics & insights

Human Intelligence

- Operational Experts
- Actuarial Experts
- Finance Experts
- Clinical Experts
- Market Experts

Technological Intelligence

- Generative AI
- Predictive Models
- Machine Learning
- Human-in-the-loop Workflows

CARE DELIVERY ENABLEMENT

End-user technology tools

Physicians

- Point-of-Care Insights
- High-Acuity Patient Management
- Clinical Pathways Workflow

Partner Operations

- Cost of Care Workflows
- Prioritized Scheduling
- Transitions-of-Care Workflow

agilon Operations

- Partner Performance Analytics
- Financial Planning
- Central Operations

Insights

- A 360° view of each member — stitching longitudinal payor and provider data across sources and timescales
- Actionable insights embedded in operational and clinical workflows — tailored to drive best next steps across every role in the care continuum
- Proximity to the physician enables insights to support action at the point of care

Data Security & Compliance

Note[1]: HIE stands for Health Information Exchange

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Connecting data to care: earlier identification and treatment of high-risk patients

Ingestion

Financial data from payor partners combined with practice data and clinical feeds from EMRs[1], HIEs[2] and real-time ADT[3]

Aggregation

A comprehensive view of each member — bringing together information from payors, providers, and the community

Insights[6]

Identification of potential undiagnosed conditions for physician review, care gaps, screening eligibility, and protocol gaps

Action

Insights delivered directly into the PCP's[4] EMR at the point of patient care

Outcomes

- Earlier and more advanced screening
- Improved treatment and adherence
- Reduced avoidable hospitalizations and readmissions
- Efficient delivery of information and tracking actions

200M+	700M+	~2M	150M+	65+	120+
clinical documents on the platform[5]	lab results across the full continuum[5]	hospitalizations tracked[5]	claims ingested since 2016[5]	payor partner connections[5]	EMR[1] instances integrated across major vendors[5]

Note[1] EMR stands for Electronic Medical Records. Note[2] HIE stands for Health Information Exchange. Note[3] ADT stands for Admission, Discharge, Transfer. Note[4] PCP stands for Primary Care Physician. Note[5] All metrics reflect totals from inception to September 17, 2026. Note[6] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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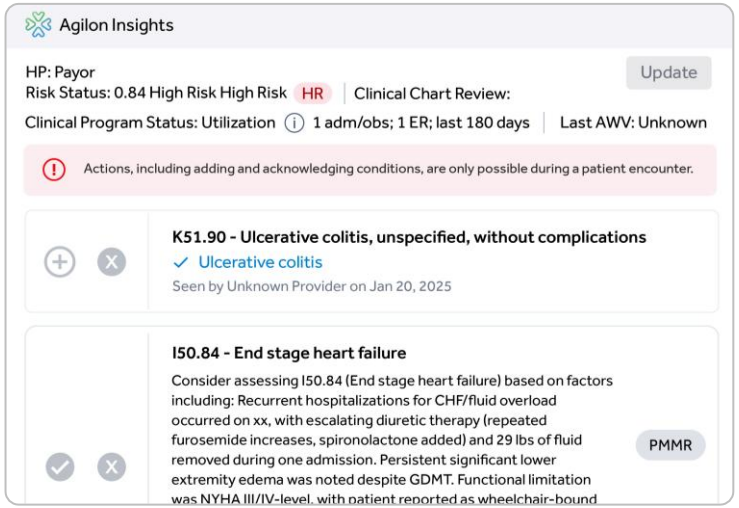
Insights embedded in the care workflow

PCP

GenAI clinical insight memos at the point of care

Surfaces relevant clinical conditions, screening needs, and AI-generated clinical insight memos inside the existing EMR[2,4] workflow at the point of care.

Why it matters: agilon-tuned memos cite dated clinical evidence for PCP[3] assessment and are refined by clinicians. All diagnoses are determined by the treating physician based on independent clinical judgment.

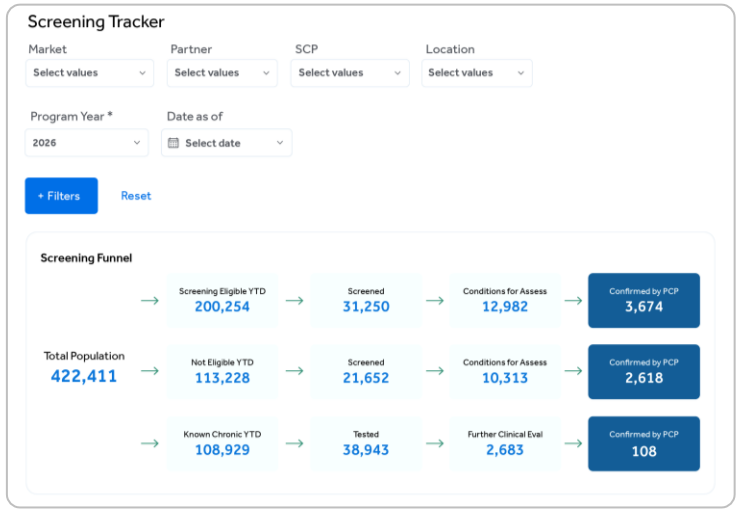


PHYSICIAN + OPERATOR

Clinical pathways: Screening to adherence

Identifies patients eligible for critical screenings and flags them to physicians and operators for scheduling.

Why it matters: Once diagnosed, the platform tracks protocol adherence to support improved patient outcomes.

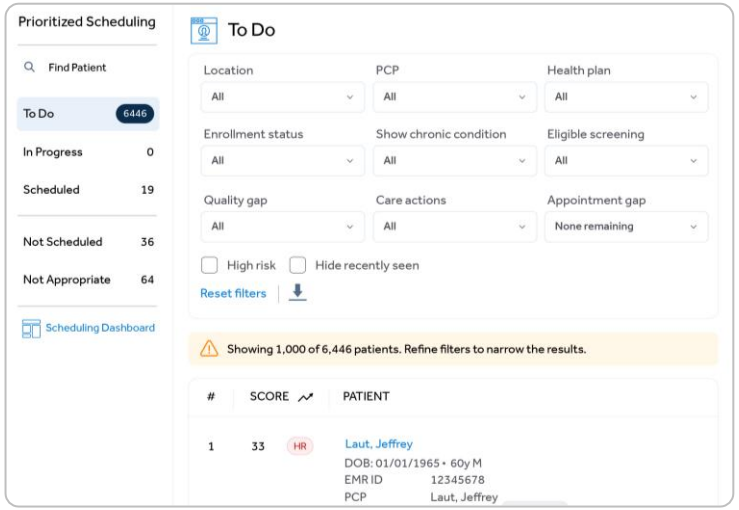


OPERATOR

Prioritized scheduling

Worklists sort patients by clinical need so schedulers can focus on the highest-need patients first.

Why it matters: More touchpoints translate into more active care management.

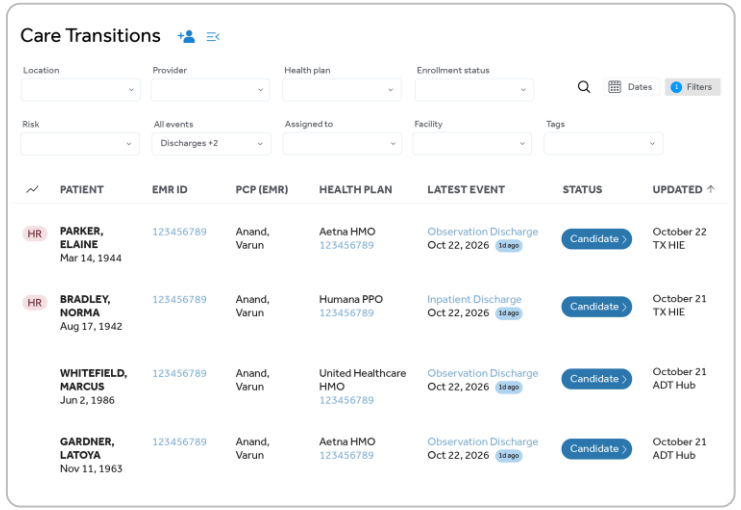


CARE TEAM

Transitions of care

Real-time hospital admission and discharge alerts drive rapid outreach to see discharged patients within 7 days.

Why it matters: Timely PCP[3] follow-up can help reduce readmissions and avoidable utilization.



Note[1] All images are illustrative. Patient and provider names, dates of birth, EMR IDs, and other patient details shown in screenshots are fictitious. The GenAI clinical insight memo reflects de-identified patient information. Note[2] EMR stands for Electronic Medical Records. Note[3] PCP stands for Primary Care Physician. Note[4] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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Focus area:
Clinical Pathways



Dr. Karthik Rao
Chief Medical Officer, *agilon health*

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One repeatable framework scalable across conditions

A structured, end-to-end approach to managing chronic conditions in the primary care setting



1 Identify

Identification and stratification of high-risk patients based upon data review

2 Diagnose

Appropriate testing is completed to confirm or rule out the condition

3 Treat

Evidence-based medical therapy is initiated and optimized by the primary care physician (PCP) with additional support as needed (e.g., pharmacy, virtual dementia clinic, etc.)

4 Follow Up

Ongoing monitoring, specialist referral as appropriate, and end-of-life care for late-stage patients.

5 Outcomes

Measured by earlier identification of conditions, optimized treatment and improved adherence, reduced avoidable utilization, improved patient satisfaction and related quality scores

Driving measurably better outcomes while reducing avoidable utilization

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An integrated framework for action-oriented patient care

	1 Identify	2 Diagnose	3 Treat	4 Follow-up	5 Outcomes
agilon Clinical Pathway Standards	• Pathway definition • Identification & risk prioritization	• Diagnostic criteria and recommendations • Barrier identification & resolution	• Surface guideline-aligned treatment • Barrier identification & resolution	• Lab, diagnostic, & visit tracking • Incomplete action work	• Clinical outcomes measurement • Process performance tracking across the pathway
Embedded Technology	• AI and evidence-based identification of potential undiagnosed conditions for physician review[1] • Prioritization workflow tools for schedulers and care teams	• Point-of-care insights tool	• Point-of-care decision support intelligence • Medication data · pharmacy support tools	• Registry · alerts · care pathways workflow · pharmacy/lab data feeds • Referral management · specialist directory · clinical alerts	• Performance dashboards - claims/clinical analytics
PCP / Care Team Action	• Schedule patients based on priority at right site of care	• See patient and engage with recommendations on point-of-care tools • Order & testing evaluation	• Clinical decision-making & treatment integrated into point of care • Pharmacy-supported therapy	• Reassess & treatment adjustments • Specialty & palliative referrals	• Variation review • Implementation reviews

Note[1] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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Clinical pathway: congestive heart failure (CHF)

#1
Cause of potentially preventable hospitalization in Medicare patients[1]

~40%
Increase in age-adjusted HF mortality rate between 2010 and 2023[2]

$30K+
Avg annual cost per CHF patient[6]

~20%
30-day readmission rate (national avg)[3]

agilon CHF pathway: identify → diagnose & treat → follow-up

Identify

- AI flags high-risk CHF patients
- Emergency department utilization pattern review
- BNP/NT-proBNP[4] trend monitoring

Diagnose & treat

- Provider-level support for guideline directed medical therapy (GDMT) (e.g., POC[5] information, patient lists)
- Operational reporting for GDMT to drive performance
- Pharmacist support for GDMT management

Follow-up

- Structured 48-72hr post-discharge follow-up
- Monthly care coordinator touchpoints
- Specialist co-management with cardiology

Note[1] Nyweide DJ, et al. JAMA Intern Med. 2013;173(20):1879-1885. Study population: Medicare fee-for-service beneficiaries aged 65 and older. Note[2] Gorodeski EZ, et al. *J Card Fail.* 2026. (HF STATS 2026, Heart Failure Society of America). Note[3] Blecker S, et al. *J Am Coll Cardiol.* 2019;73(9):1004-1012. Note[4] BNP/NT-proBNP stands for B-type natriuretic peptide/N-terminal pro-B-type natriuretic peptide. Note[5] POC stands for Point of Care. Note[6] Heidenreich PA, et al. *J Card Fail.* 2022;28(3):453-466.

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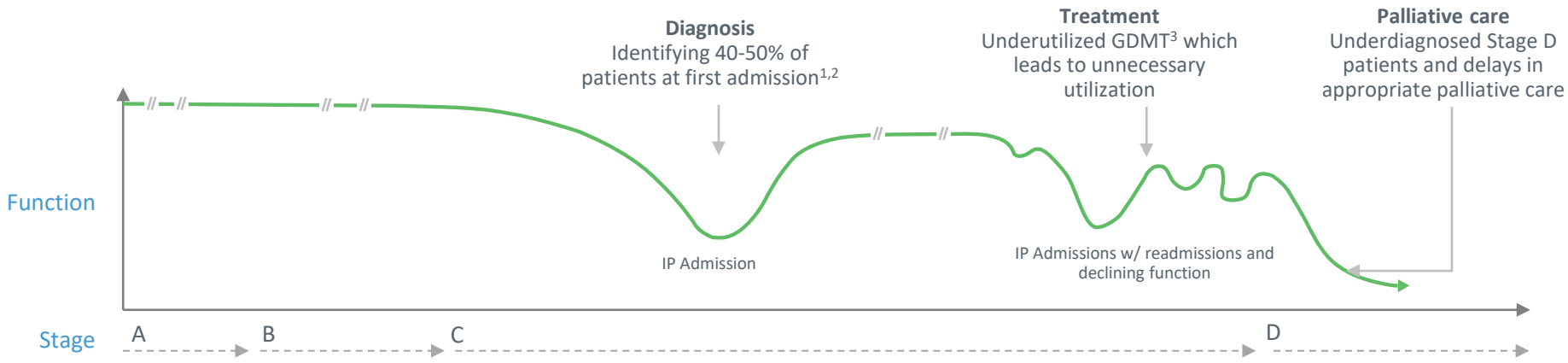
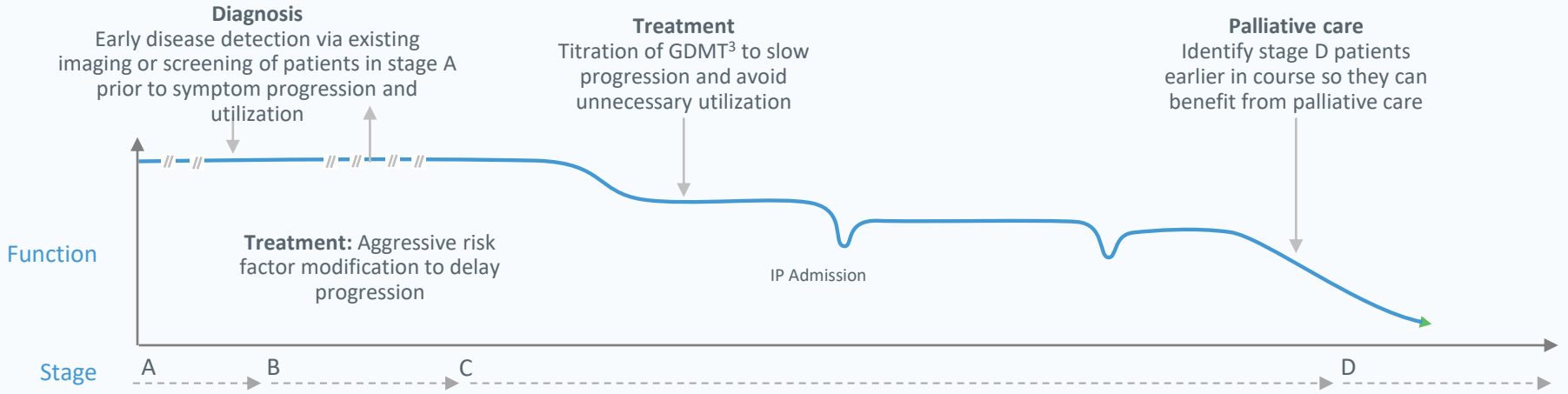
Evidence-based clinical actions across the heart failure pathway to meaningfully improve outcomes and quality of life for patients

Heart failure patient journey *without* agilon pathway[4]



High-quality heart failure journey *with* agilon pathway[4]



Note[1] Sandhu, Alexander T et al. "Disparity in the Setting of Incident Heart Failure Diagnosis." *Circulation: Heart Failure* vol. 14,8 (2021): e008538. doi:10.1161/CIRCHEARTFAILURE.121.008538. Note[2] Tisdale, Rebecca L et al. "Predictors of Incident Heart Failure Diagnosis Setting: Insights From the Veterans Affairs Healthcare System." *JACC: Heart Failure* vol. 11,3 (2023): 347–358. doi:10.1016/j.jchf.2022.11.013. Note[3] GDMT stands for Guideline-Directed Medical Therapy. Note[4] Illustrative; conceptual depiction of patient function over time.

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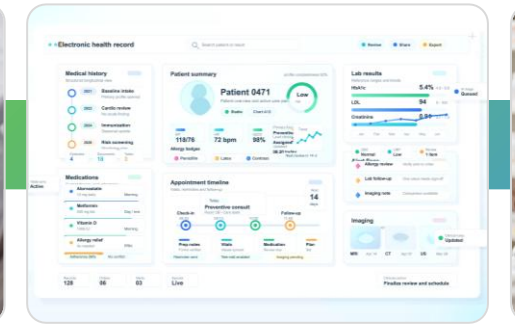
From frequent hospitalizations to renewed independence

A patient's journey through enhanced care clinic: HF[1]











Initial

Retired patient with COPD[1] and HF[2]; 14 emergency room visits within six months prior to enrollment to 7 in the six months following enrollment.

Diagnosis

Conditions suboptimally managed at care program enrollment; loss of family medication support led to nonadherence, worsening disease, and situational depression.

Intervention

Pharmacist-led medication review and reconciliation with enrollment in medication assistance programs, adherence education, and a home visit

Follow-Up

Optimization of all four GDMT[2] pillars; ongoing follow-up with pharmacist who confirms adherence; ongoing and close collaboration with Cardiology for heart failure care

Outcomes

- **ER visits decreased** by 50%.
- **Depressive symptoms improved** as conditions were better controlled
- **Regained independence and confidence** managing own health
- **Returned to a longtime hobby** set aside during period of health decline

Note[1] HF stands for Heart Failure. Note[2] GDMT stands for Guideline-Directed Medical Therapy

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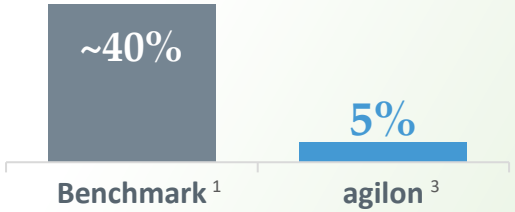
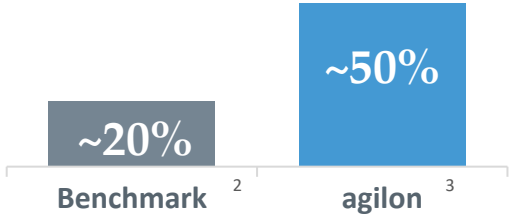
Heart failure pathway supports proactive diagnosis and optimization of Guideline-Directed Medical Therapy (GDMT)

Reduced diagnosis of heart failure in an acute setting



% Heart failure diagnosis in acute setting

Virtual pharmacy patients on all four GDMT pillars



% Heart failure patients with reduced ejection fraction on all four GDMT drug classes



NPS 87[3]

98%

agree they receive comprehensive, high-quality care[3]

Note[1] Sandhu, Alexander T et al. "Disparity in the Setting of Incident Heart Failure Diagnosis." *Circulation: Heart Failure* vol. 14,8 (2021): e008538. doi:10.1161/CIRCHEARTFAILURE.121.008538. Benchmark reflects nearly 1M commercially insured and Medicare Advantage adults with new HF diagnoses, 2003–2019. Note[2] Keykhaei, Mohammad et al. "National Impact of Optimal Implementation of Guideline-Directed Medical Therapy in Heart Failure With Reduced Ejection Fraction." *JACC: Heart Failure* (2026): 103295. doi:10.1016/j.jchf.2026.103295. Note[3] agilon health metrics are calculated as of December 31, 2025. Acute-setting diagnosis rate reflects agilon MA patients with new HF diagnoses.

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Clinical pathway: serious illness care (palliative and hospice)

~50%
Fewer hospital admissions with community-based palliative care[1]

52.9%
Medicare decedents who used hospice in 2024[2]

74%
Non-hospice cancer patients dying in a hospital or facility, vs. 14% with[3]

71%
Americans preferring to die at home, vs. 31% who actually do[4]

agilon Serious Illness Care Pathway: Identify → Diagnose & Treat → Follow-up

Identify

- High-risk patient review by a dedicated clinical reviewer to surface potential hospice-eligible patients
- Eligibility assessment applied
- Patients flagged when appropriate and routed to PCP for review

Diagnose & Treat

- Designated clinical reviewer identifies patients who may meet eligibility criteria such as:
  - Terminal prognosis (<6 mos)
  - Evidence of functional and/or clinical decline
- Structured clinical summary and individualized care plan created and reviewed by PCP

Follow-Up

- PCP initiated goals-of-care conversations
- Support timely and appropriate hospice enrollment for eligible patients
- Structured support for caregivers and patients with RNs and care teams

Note[1] Scibetta C, et al. *The Costs of Waiting: Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center.* J Palliat Med. 2016;19(1):69-75. Note[2] MedPAC, March 2025 Report to Congress. Note[3] Obermeyer Z, et al. *Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer*. JAMA. 2014;312(18):1888-96. Note[4] Kaiser Family Foundation. *Views and Experiences with End-of-Life Medical Care in the U.S.* KFF, 2017.

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Clinical pathway: dementia

$105.9B
2025 Medicare costs associated with dementia[1]

60%
Dementia cases in the US undetected[2]

10%
Estimated U.S. prevalence among adults 65+ (2016 data)[3]

60%
Dementia patients who wish diagnosis had come sooner[4]

agilon Dementia Pathway: Identify → Diagnose & Treat → Follow-up

Identify

- Systematic cognitive screening and evaluation for patients 65+
- AI-enabled flagging through clinical pattern recognition[5]
- Standardized screening approach based on risk-stratification including both brief and comprehensive tools

Diagnose & treat

- Multiple options to conduct evaluations for applicable patients
  - PCP conducts full dementia eval
  - Trained SME performance eval
  - Telemedicine Referral Partner conducts two-visit eval
- Structured diagnosis report and individualized care plan created and reviewed by PCP

Follow-up

- Care Ecosystem Model: monthly+ patient/caregiver touchpoints
- Medication reconciliation, safety screening, and caregiver well-being checks
- Advanced care planning & behavioral management guidance
- Specialist co-management and referral to community resources

Note[1] USC Schaeffer Center for Health Policy & Economics. *The Cost of Dementia in 2025*. April 23, 2025. Note[2] Lang et al. *BMJ Open*. 2017;7(2):e011146. Note[3] Manly JJ, et al. *JAMA Neurol.* 2022;79(12):1242–1249. doi:10.1001/jamaneurol.2022.3543. Note[4] Banerjee S, Rahman-Amin M, Eul-Barker N. *Int J Geriatr Psychiatry*. 2022;37(6). Note[5] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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Strong execution, demonstrated results

Results observed across agilon's embedded programs, partner relationships, and PCP execution

10%

Lower hospital admissions[1]

For agilon MA patients as compared to Medicare FFS benchmarks[2]

24%

Lower readmission rate (readmit) [1]

For agilon MA patients as compared to Medicare FFS benchmarks[2]

8%

Lower emergency room utilization (ED) [1]

For agilon MA patients as compared to Medicare FFS benchmarks[2]

87

Patient satisfaction (NPS) [1]

Based upon agilon MA patient surveys

Note[1] agilon health, *2025 Impact Report* (MY 2025 data). Note[2] CMS, *Medicare Geographic Variation – by National, State & County* (2023/2024 data; Original Medicare FFS, standardized spending). data.cms.gov. Accessed October 2026

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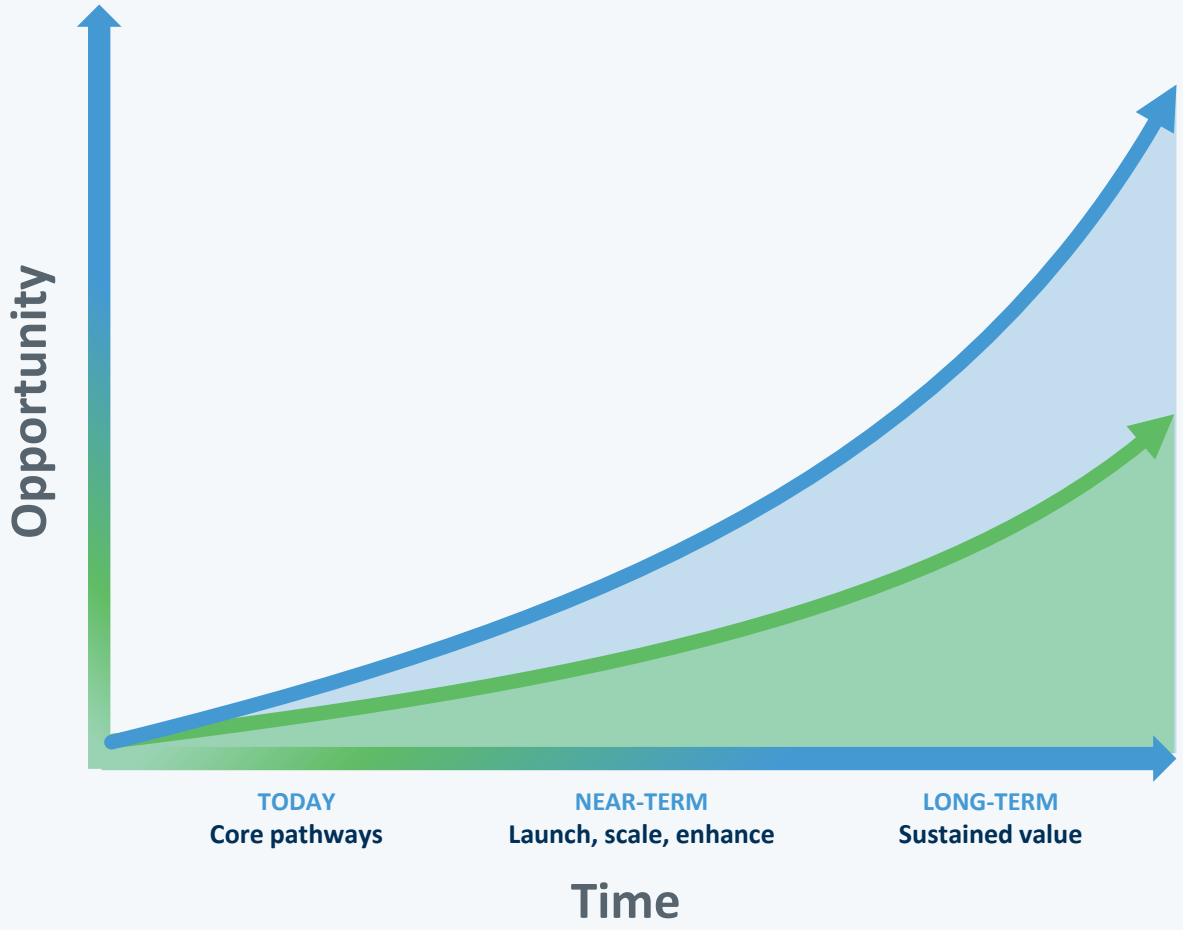
Future pathway creation balances opportunity and complexity while considering time to impact[1]

A disciplined roadmap: expanding our care model to additional complex care conditions while enhancing existing pathways to improve patient outcomes



1

Enhance current pathways

Optimize existing programs to improve patient experience and outcomes

- Heart failure
- Serious illness care
- Transitions of care
- High-risk patient management

2

Launch & scale new pathways

Building upon existing framework and infrastructure to address additional complex medical conditions

- Oncology
- Lung health
- Musculoskeletal
- Cardiology
- Dementia

Note[1] Illustrative; not to scale. Does not represent a financial projection.

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Focus area:
Physician Engagement



Dr. Jon Copeland
Family Physician, *United Physicians*

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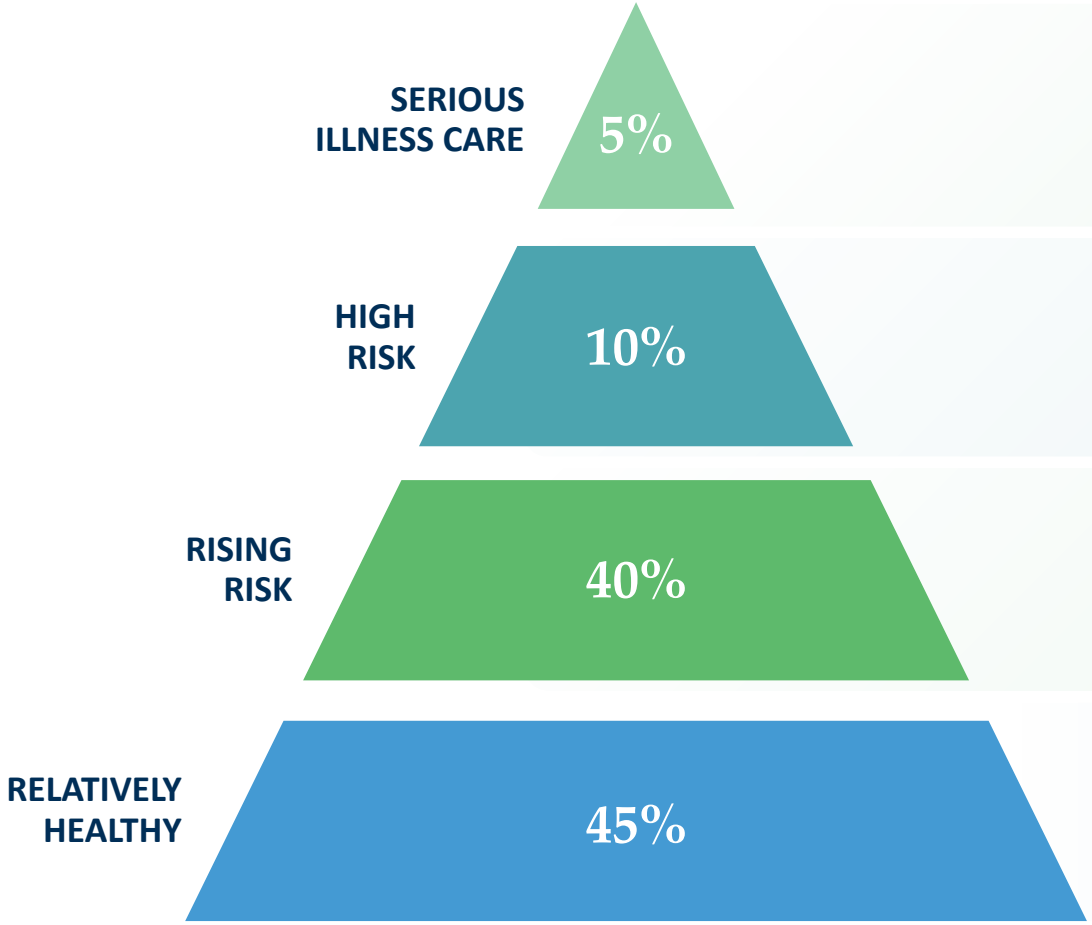
Proactive management: aligning status with clinical focus to understand and act on patient trajectory



Manage complexity – serious illness care

Change trajectory – prevent further decline, protect quality of life

Early intervention – alter trajectory

Routine care – preserve health

Developed to enhance physician engagement and patient outcomes alongside integrated clinical pathways for the highest-need patients

Note[1] Risk stratification pyramid is a conceptual model commonly used in population health management; percentages do not represent agilon patient data.

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Proactive management: how it works



Identify

PCPs and multidisciplinary care teams convene regularly to review high-needs members inclusive of those categorized as:

- Rising risk
- Declining
- Complex



Intervene

Individualized 90-day action plans are built for intervention across 6 primary domains:

- Emergency department / hospital prevention
- Visit frequency
- Care management
- Medication optimization
- Caregiver support
- Goals of care / hospice



Reassess

Patients exit intensive management only when certain criteria are met:

- No unplanned hospitalizations
- Primary care visits proactively scheduled
- Care management enrollment
- Advanced care plan
- Medication optimized
- Specialists reviewed
- Quality gaps closed

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Inside a review: proactive management in practice

Adapted example of the review process

								Action Plan
Initial Discussion Date	**Date of Most Recent Discussion**	**Health Trajectory**	**PCP Visit Frequency**	**Needs CM**	**Needs Palliative/ Hospice**	**Needs Med Review**	**Needs Condition Review**	**Notes/Action Plans**
02/01/2026	08/01/2026	Stable		None	None	No	No	Utilization related to surgeries; is planning two more surgeries this year. Just had pre-op for planned procedure. No action needed.
02/01/2026	08/01/2026	End-of-life	2	Practice CM	Palliative	No	Yes	Artery problems. Says there is a reminder note in the chart to discuss palliative/hospice. A year ago, PCP didn't think patient would be alive now, but patient still is. Last seen, no upcoming appt. Needs PCP
02/01/2026	08/01/2026	Declining/ Rising Risk	4	Practice CM	No	No	No	Last PCP visit when patient was preparing for carpal tunnel surgery. CM did engage with patient after, provided education on diabetes, diet, refused to schedule PCP visit. Hospitalization.
02/01/2026	08/01/2026	Declining/ Rising Risk	4	Practice CM	Palliative	No	No	Shouldn't be living at home, needs to be in a SNF. Often misses PCP appts. Dementia and many psychiatric dx. Last appt was telemed, no upcoming appt. CM initiated additional support services.
02/01/2026	08/01/2026	End-of-life	4	None	Hospice	No	No	Has had a lot going on. Hospice appropriate patient, can get involved to bridge the gap. Complex patient. Patient went to hospital recently; Residential following and will restart hospice.
02/01/2026	08/01/2026	Declining/ Rising Risk	4	None	Palliative	No	No	Urinary tract malignancy & breast cancer – on chemo. Complex cancer patient followed by oncology specialists.

Each partner optimizes their engagement approach in combination with agilon's technology and clinical pathways to serve their patients and improve health outcomes

Note[1] Example adapted from a partner review process. Patient details have been modified and generalized to protect patient privacy.

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Focus area:
Quality Programs





Heidi Hittner
Chief Business Operations Officer, *agilon health*

Dr. Jon Copeland
Family Physician, *United Physicians*

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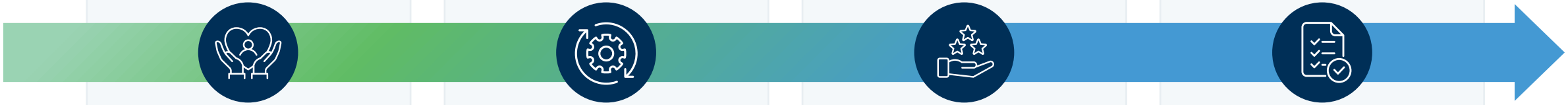
Quality. Every patient. Every visit. Every opportunity.

A value driver for patients, physicians and payors at every step in the care continuum



Better patient care

Through whole-person, coordinated care, our programs enable earlier detection of conditions via preventive care and drive better control of chronic disease across our patient population

Easier gap closure for our partners

Care reinforced by accurate clinical documentation and validation supports accurate quality reporting, with clear and actionable priorities at the point of care and integrated workflows to reduce administrative burden and help close gaps

Stronger Stars for payor partners

Efforts drive meaningful Stars improvement by closing care gaps and meeting quality measures, ultimately delivering stronger performance and greater value across our network

Value differentiation

agilon's quality performance supports:

- Strong quality performance across payor partners
- Enhanced quality incentives
- Measurably stronger patient outcomes

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Blood pressure control: A major modifiable lever on CVD

The clinical case

- Hypertension is one of the most common, modifiable drivers of cardiovascular death in the U.S. — and one of the most under-controlled.
- The CDC estimates that patients with high blood pressure are 4x more likely to die from stroke and 3x more likely to die from heart disease.[5]
- Managing blood pressure to target reduces cardiovascular mortality by 20%[3], and lowers risk of cardiovascular events such as heart attack, stroke, and kidney disease by 25%[3].

121.5M

U.S. adults ≥20 have high blood pressure[1]

670K+

Annual U.S. deaths with hypertension as a cause[2]

20%

Drop in cardiovascular mortality with medication treatment for BP[3]

43.7%

of adults with hypertension had it controlled in 2017-2018 (down from 53.8% in 2013-2014)[4]

Note[1] American Heart Association Newsroom, April 2021. Note[2] Cunningham et al., *J Public Health Manag Pract*, 2023. Note[3] Wei et al., *JAMA Netw Open*, 2020. Note[4] Muntner et al., *JAMA*, 2020. Note[5] CDC, Vital Signs, September 2012. Note[6] CVD stands for Cardiovascular Disease.

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A quality playbook across chronic care, prevention & experience



Chronic condition management

- **Diabetes**: Hemoglobin A1C control, annual eye exam, kidney disease monitoring, medication adherence
- **Cardiovascular**: statins, medication adherence
- **Hypertension:** blood pressure control, medication adherence
- **Osteoporosis** management after fracture



Reducing unnecessary hospital admissions

- **Care Coordination** to see patients quickly after inpatient or emergency visit
- Comprehensive **medication reconciliation** and patient engagement
- **Help prevent** unnecessary admissions with proactive primary care touchpoints



Prevention

- **Screenings for Preventative Care:** colorectal cancer screening, breast cancer screening
- **Monitoring and deprescribing** when patients take multiple medications that may have harmful side effects



Patient experience

- **Proactive patient surveys** after each PCP visit to gather feedback
- **Monthly PCP level insights** and feedback from their patients with best practices on how to improve where needed

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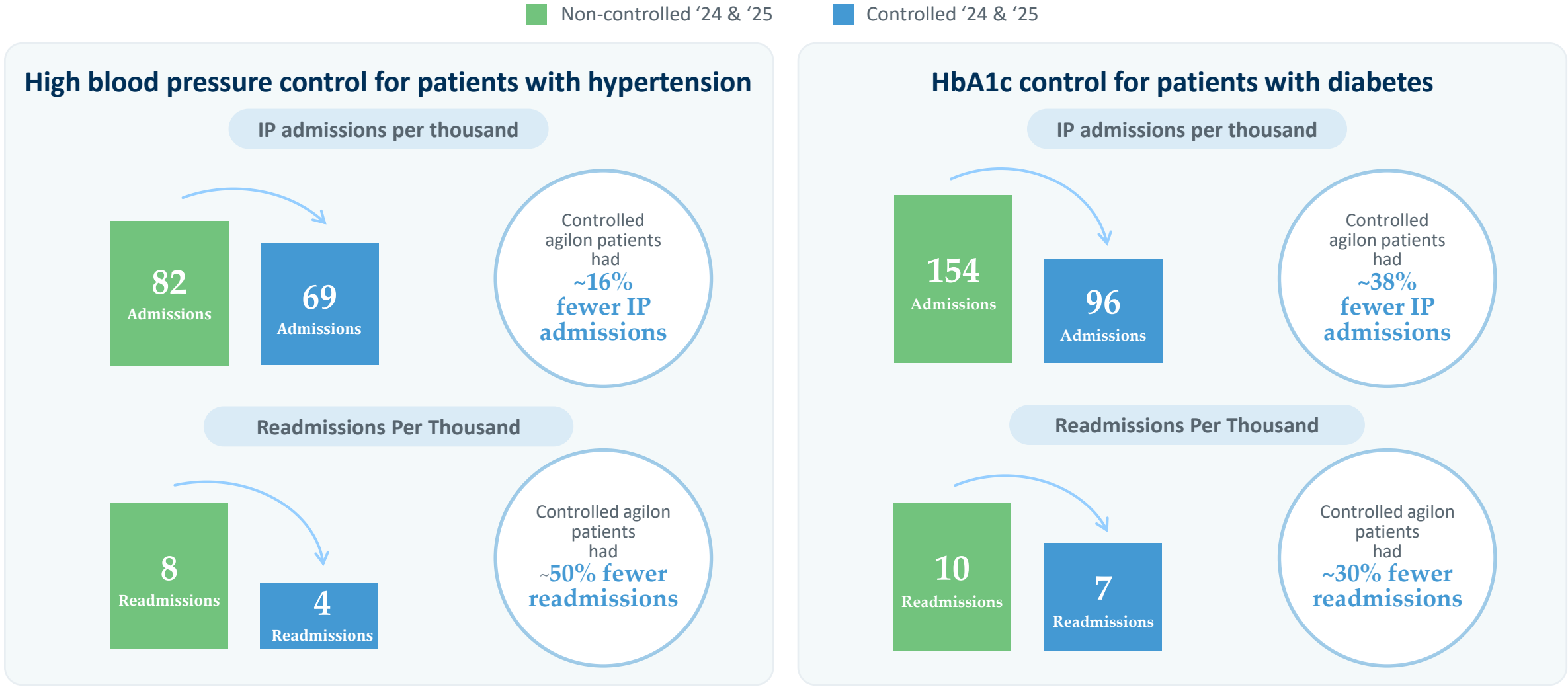
Effective condition management linked to lower utilization[1]



Note[1] Compares agilon MA patients whose condition was controlled vs. not controlled, as defined by the CMS Star measures for Controlling High Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD), among patients with complete data in the Enhanced Data Pipeline for measurement years 2024 and 2025. Observational comparison; cohorts may differ in characteristics other than condition control, and results do not establish causation.

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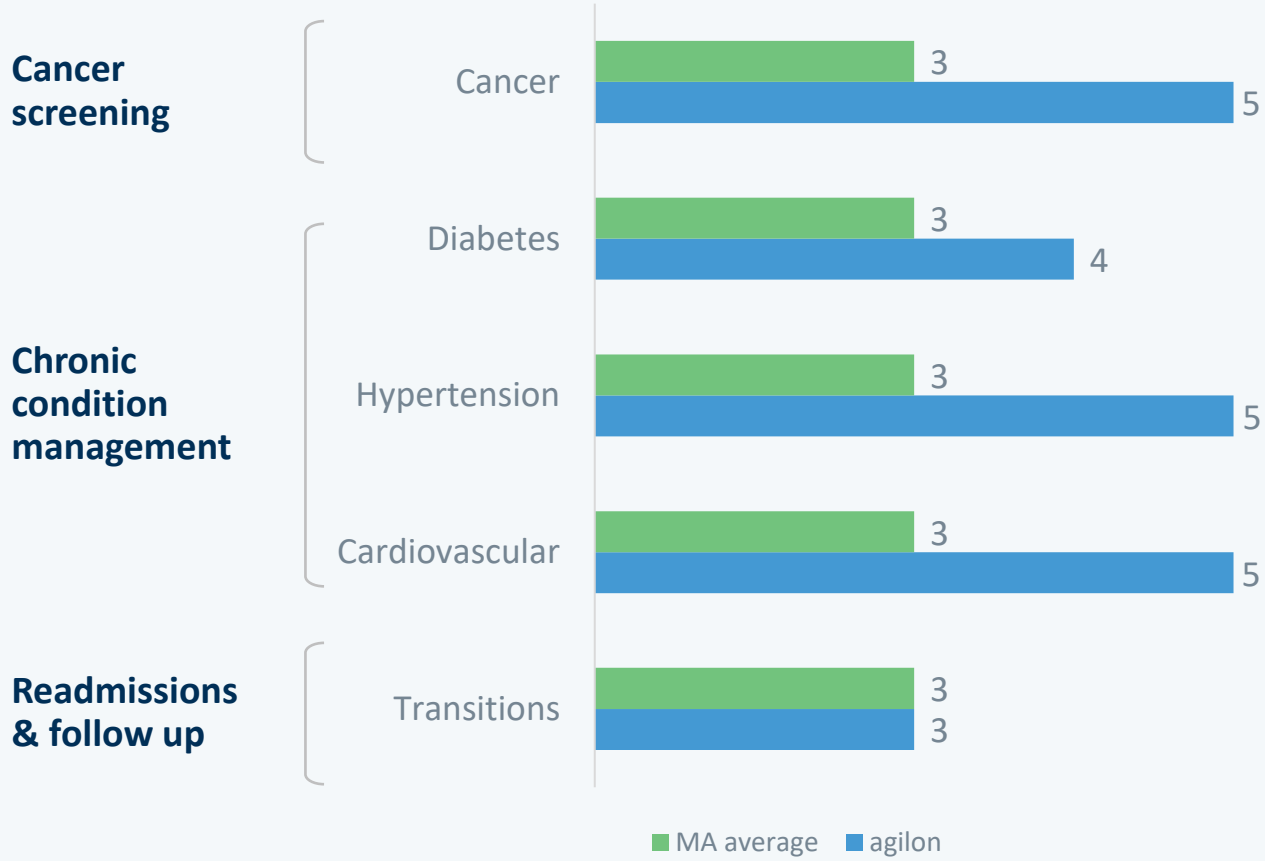
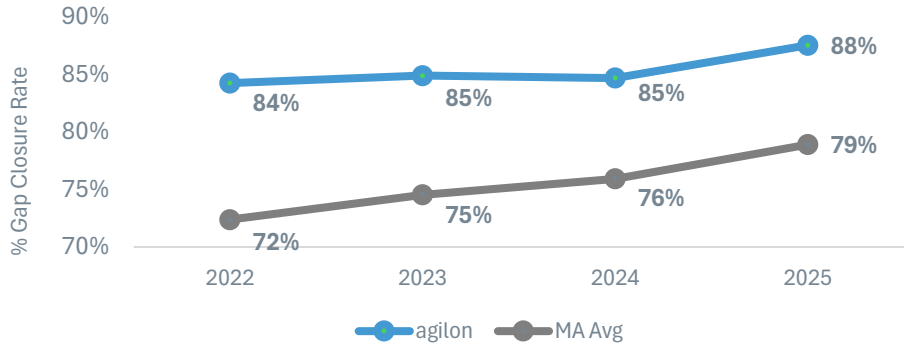
Strong quality outcomes across MA and ACO populations

Key Star measures[1]



Star Gap Closure Rate[1]



83%
AWV completion rate[2]

93%
chronic condition assessment rate[2,3]

4.2★
average Stars rating, agilon-calculated (MY 2025)[1]

98%
Patients who agree they receive comprehensive, high-quality care[2]

Note[1] agilon MA population, 2025 measurement year quality data. Includes a subset of Stars measures; MA average per CMS data. Note[2] agilon MA and ACO populations, 2025 measurement year quality and patient survey data. Note[3] The Burden of Illness (BOI) Program is designed to improve the collection of accurate information about patient medical conditions for the purpose of advancing quality care and coordination to achieve better health outcomes and decrease health expenditures. agilon health operates at all times consistent with applicable laws, regulations, and guidance, including with respect to RAF coding.

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A model built to compound value for patients and partners

As more physicians engage with agilon's programs, partners benefit—empowering physicians to deliver higher-quality care, reducing the total cost of care, and improving outcomes for the patients who need it most.



agilon delivers

- Elevated patient-centered care through **deep, embedded partnerships with physician partners**
- Demonstrable patient outcomes through **clinical excellence and physician engagement**
- Demonstrated quality improvement through **comprehensive care and rigorous focus**
- Expanding network value through **durable and deepening payor and provider relationships**

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Questions?



Answers.

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