Inogen, Inc.
Investor Day
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Presenters
Nabil Shabshab - President and CEO
Kristin Caltrider - CFO
Stanislav Glezer – CTO
Agnes Lee – SVP Investor Relations & Strategic Planning

Q&A Participants
Mike Matson - Needham & Company
Brett Fishbin – Keybanc Capital Markets, Inc.
Mathew Blackman – Stifel Nicolaus & Co., Inc.

Operator
Hello and welcome to Inogen's strategy update conference call. At this time, all participants are in a listen only mode. Management will make some remarks, and then we'll hold a Q&A session. To ask a question at that time, please press star followed by one on your touch tone keypad. If anyone has difficulty hearing the conference, please press star zero for operator assistance. As a reminder, this conference is being recorded today, February 27, 2023.

I would now like to turn the conference over to Nabil Shabshab, President and Chief Executive Officer. please go ahead.

Nabil Shabshab
Thank you, Kevin. Good morning, everyone, to people here in the room as well as people that have joined us on the webcast. My name, again, is Nabil Shabshab. I'm the President and the CEO of Inogen. And I've been with the company for just about two years now.

So before I start talking about the transformation, which is on slide three, I just want to maybe provide some context for people that are not as familiar with Inogen very briefly. So we're a global MedTech company with a footprint in about 60 countries where we commercialize our products. Our revenue in 2022 was $377 million. The more important thing is we operate in a very difficult disease state, COPD. According to the CDC, the US prevalence of COPD in 2020 was between 5.2% and 6.2%. COPD is the sixth leading cause of death in the US -- was in 2020, also, according to the CDC. The economic burden on the

US economy is about $50 billion at that time, and there were about 1.3 million COPD emergency department admissions in 2019, according to the American Lung Association.

So needless to say, before we start, we take our job very seriously in terms of helping people in that very difficult disease state and beyond in terms of going into respiratory care. But we're very focused, every single employee, delivering on our purpose of improving the lives through respiratory care every day when we come to work.

So let me cover very briefly this information. So as I said, I've been here for about two years, so Quarter 2 2021. Till today has been a very significant amount of effort and change in Inogen. I would characterize Inogen before as a HME with a great product, which we want to build on and retain in terms of part of our DNA, but more importantly, the evolution is to actually make sure that we are on our way to become a MedTech company that has a global footprint and can go beyond COPD only and to other disease states to.

So we've always characterized our strategy to have different time horizons, short to medium, medium to long. I'm going to only focus on the first two. So in the short to medium, of course, it's a combination of driving POC-based oxygen therapy, long term oxygen therapy. And I'm going to go through some details about how much runway and potential is left in that market. But also that short term includes introducing innovations so we can start generating growth from new product introductions. But more importantly, when we get to the next stage of enhancing in the medium to long term, new product introduction and building on the capabilities we have in place are going to become a critical factor for our growth. And today, we want to dedicate some of that time to be able to go through the innovation pipeline as well as make sure that we expand the periphery that we have beyond COPD.

So let me characterize on slide five why we believe that there is a lot of potential still ahead of Inogen. If you look at the data set from CMS, in terms of estimated penetration for portable oxygen concentrators, you'll realize that even in 2021 that penetration was still at 22%, which is pretty small. So the runway is really long. And there's a lot of work ahead of us and an opportunity that presents itself at the same time. If we expand our purview from only CMS data and we look at IQVIA, and that basically includes not only CMS, but private payers, that penetration is even lower than 22% way, if you look at 2021 data, it's 13.9%. So which means that the POC-based therapy is even still at its nascent stage within the larger payers and the larger data sets.

Equally important, if I look at what patients want, as characterized on the right hand on the slide, we believe that there are some key things that we've uncovered in our own quantitative research in 2021 that are very telling about the state of the disease itself as well as the industry. About three quarters of the people strongly believe that there is a meaningful difference between oxygen tanks and POCs. The

findings that concurrently with the fact that two thirds of them want more control about what device that they acquire when they have COPD. And then I add it to the fact that also two thirds of them believe that brands matter in portable oxygen concentrators. And then I add to it on top of it that about half of them were never informed of the POC optionality when they were diagnosed and prescribed. That tells us that the runway is still long ahead of us. And there's plenty of growth opportunity, not only from a market penetration perspective of the modality, but also from the attitudes of the patients as well as the prescribers.

On slide six is one of the slides that we want to focus on today about the transformation in terms of how are we planning on growing by optimizing our channel mix, and it's really important. So today, if we look at Inogen in the past, as well, as partially before we came, we were on the right hand side, we were downstream. And I'm going to characterize that model. As we were waiting for a patient to get diagnosed, as well as prescribed upstream. And then we were waiting for them to be on a certain modality. After that they might get dissatisfied with the modality that they're on. Then they see our advertising, they actually react to it. And then they come into my funnel. And I try to convert them into either a cash sale patient or a rental patient if they can't afford to pay for it.

So you look at it and you say that's counter to the patient diagnosis, prescription, and buying journey. Buying journey meaning if I buy or if I rent. It’s like the opposite. We were waiting downstream for all of this activity to happen upstream and for people to sort of come down that path. And then I was focusing on selling them for cash. And one of the channel evolution vectors that we have is we're going to actually keep the three channels that we have upstream and prescriber where we're going and investing our partnership in B2B, but also equally important or DTC that we're not going to actually give up on because it's a unique differentiator, to be able to look across the channels, optimize our footprint, optimize our investments and where we're building for growth, all for the reason that if we are going to scale based on the opportunity that we just highlighted to sell very low in terms of penetration, it has to happen within the prescriber channel as much as it is on the DTC side, and then in conjunction with the partners that we have in the middle.

So let me sort of cast a slightly different lens. I'm going to focus on slide seven, on only a prescriber and DTC. And people are sometimes asking us, so why are you now optimizing the channel strategy? So why now? And what is it going to yield? So these numbers are, of course, illustrative, they're based on hard numbers, but with we have tried hard to make things much more digestible. And they are basically in comparison to DTC being the base. So let me start with the four lenses very simplistically, is the channel scalable and predictable in terms of forecasting revenues and so on, the sales and marketing cost reasonable, so I can get a contribution margin that I want or an ROI, and is then the lifetime value of the patient and or the prescriber high enough, meaning I can scale profitably and I can drive high level of growth, and then, is the contribution margin where we need it to be?

So let me start on the right hand side for the DTC channel. So if you think about scalability and predictability, we rank this at half. And the reason there, we've been saying for a while that the DTC model is a one to one model, meaning I have one lead that I have to generate, at the end of it, there's one patient, and then with that patient comes one POC and possibly a few accessories. So that is not a very scalable model because every time I want to sell a POC I have to spend that money and generate that lead. And then beyond that, I can't scale. I sold you the device. And we all know the lifespan of patients with COPD is between four and five years depending on what data you look at. So there's not a lot of lifetime value for that patient at the end of it. And you'll excuse me be including clinical and cold in how I'm describing it, it's just from a business perspective.

But if you look at the prescriber channel on the opposite end, this is a one to many model. It's very simple in terms of characterizing that way. And the reason we say one to many is I can actually deploy a salesperson, they develop a relationship with a prescriber, and that prescriber will give me prescriptions that call in three to four illustratively a month and perpetuity as long as they're practicing provided I deliver on my promise both in the product and the service that I have. So you look at these investments and you say okay, what is very scalable, almost the same cost. One is not.

So let me get to the cost in terms of sales and marketing. So on the DTC side, we all know as you can see in our marketing spend that there is a significant amount of spend for me to actually feed that channel. And I'm going to go into that more in detail later on. On the prescriber side, the cost, and I'm simplifying, the cost is mainly the cost of the feet on the street, which is the salespeople that I put in place and the support network that I give them. But the sales and marketing expenditure on one side is much lower than the DTC side.

Then the lifetime value I've covered, I'm going to just set a couple of points, one device, set of accessories on the DTC side. On the other side, multiple prescriptions, multiple patients, multiple devices with the accessories that come with them, albeit on a rental model versus on a cash sale model, but still, the lifetime value of that patient compared to the prescriber that I developed for the same -- roughly the same amount of spend is very different.

If you look -- if you want to boil that down and say okay, let's boil it down to one metric, what's the contribution margin on the channels? And why are you making a change? While I'm going to stress again, we're not walking away from the DTC, but there is room for optimization. I look at the contribution margin half a Harvey Ball to one at scale. When I scale the prescriber channel, you can say that, okay, I need that balancing factor in my channel strategy and in my mix to be able to not only growth, but profitable growth like we are aspiring to and the shift recently. So when we came about two years ago, the focus was on building capabilities and standing up a medical device or a medical technology

company. We've made those investments, now it's time to leverage them. But what we're aiming for is not only growth as a singular length and the yardstick, it's growth and returning to profitability in the medium to long term. So that's why it's very critical for us to now revisit channel strategy and make adjustments as required.

So let me then do a little bit of a click down on the commercial strategy and say a comparison. The rationale will be clear, but it's not as clear as when we look retrospectively. So we wanted to provide our investors with an opportunity to look back a little bit so we know how to look forward. And that's really critical. And the way we're going to look at it is I'm going to look at sort of like 2018, 2019, which were peak performance here in direct to consumer. And then I'm going to compare them to '21 and '22, which are the most recent two years with some of the changes that we made. So if you look across 2018, 2019, that had their sales of 142 and 166 million, you'll quickly realize from the scoring on the slide that this was predominantly driven by spending a lot on advertising, scaling the sales organization dramatically in numbers to be able to hit that revenue, but also driving that penetration by lowering the average selling price. So if you just plan 2018, 2019 it's a very clear story in terms of how things are actually trending. Again, just for the sake of clarity. More salespeople in the seats, much more advertising, and lowering ASP to be able to hit those peak numbers.

If you look at '21, '22, you realize that almost the opposite was happening. So I'm going to characterize it as we started taking down some of the sales headcount as we were aiming to optimize productivity and efficiency in the channel. We started also reducing advertising spend as part of the pilot. And we took ASP up at the same time, which is also evidence that, you know, what with the right sales organization, the right sales discipline, you can actually achieve results that can scale from there, but that are much more oriented towards returning an investment on that channel. That's why we say within the DTC, it's not a matter of do we want to play, it's a matter of how we play and how we scale efficiently and profitably. So we hope that this rendering in terms of retrospectively as well as what's happened recently, is an indication of prospectively, what are we trying to do and why.

So sometimes the DTC channel on slide 10 is a little complex of people understanding what the model looks like and how does it work. So I'm going to characterize it at the high level where there are two funnels that actually are stacked on top of each other. The marketing funnel is all about paying for, sourcing the leads, and then qualifying them as new to file leads. The sales funnel immediately under this taking those leads, turning them into opportunities, and closing them, as simple as that.

And people have asked us recently and asked me during discussion. So, Nabil, how do we remain highly confident that you guys are going to fix this moving forward once and for all? I'm going to just characterize very simplistically, there are six things that are in the marketing funnel and six things that we're focused on in the sales funnel.

So let me start with the marketing funnel very, very quickly. So how do we optimize advertising spend? We've done a lot of work in the pilot about what's the marketing mix, what's the channel mix in terms of the omni channel, which one basically yields a higher number of qualified leads, how do I actually get to that optimum level while I'm optimizing my spend, what qualification process do I put these leads in? Since I want qualified leads, I don't want unqualified leads at the top end of the funnel. And then once I actually do that, do I know the patient attributes? Certain patient attributes lead to a higher win close rates than others, and it's very critical for us to make sure that we understand these patients attributes, not only in the lead qualification, but also how we sell them and the messaging required to close them. And then also the mix, I get these leads over the phone. And in life transfer -- one transfers when they call 1-800 number or are they coming through the web because they fill the form. And these have different close rates. So we're optimizing that too.

So just for clarity, again, at the top of the funnel, there are six finite things that we've learned from the pilots method the most. Within the six, there are a few that are even more critical than the others, but we're very focused in terms of applying the learning from the pilots, and then moving them forward into scale in Q1 and Q2.

So that's about the funnel, let me quickly go through below the funnel. And this is all about sales discipline. So let me start where we stood up a sales operation function that's capable of feeding the organization with the right numbers, measuring them against the right metrics, and being able to report them out very clearly. But so there's a combination, how do people -- this is the inside sales organization. How do people spend their time? What do they focus on? How are they utilizing that time is very critical for us. And we've known that there are variability. And I'm going to demonstrate it with an example later on. How do you develop your pipeline from the leads that you're getting? There is a discipline and a skill in building the right pipeline, calling it at the right time, within the right frequency within the right amount of time, meaning that time to first contact with that lead. And then that could result into closing sales. But that also has sales techniques within it. So we've isolated that as a variable in terms of the training that we're providing after the pilot and then help people improve their selling skills.

There's also a leader teacher aspect in terms of the management layers and the old structure. So we've now refined what that org structure is going to look like. So people have enough help and coaching, but also they have enough time to sell. And then of course, rep tenure that we've been talking about, people need time to scale their skills. So there is rep tenure within that.

So again, as a takeaway from this slide, I'd like you to think about that there are very finite, not only about the funnel buy below the funnel variables are part of the scaling as we learn from the pilot that we've applied in Q3, Q4 in '22. And we apply them in the first half of 2023.

So let me maybe -- so talk is easy and cheap, but let me demonstrate with a real example. And we just did a comparison. So these are similar groups under different managers, same tenure, same number of people relatively, and the illustratively. So if you apply some of the disciplines that we're talking about, specifically below the funnel, before we improve the marketing funnel. So the team that is being managed much more stringently and in terms of teaching people and scaling the skill, managed to do 46% more calls a day, compared to the -- these are almost 10 people in each group for the sake of illustration. So about 50% more calls per day, which is a very indicative way of how to work your funnel.

The talk time, which is important. Once I get a patient on the phone, the talk time really matters in terms of handling objections and closing them. So they've improved their talk time by 24%. Now, opportunities that were moved from new to file lead to opportunity went up 15%, which is also very important. The number of units sold is up 7%. And the conversion rate from new to file into sale is up 11.2%. So even at that level, before we go to higher level metrics, it's very important to see that these are very promising productivity results that now are in the process of being scaled in Q1 and Q2 for 2023.

So let me click one level up in terms of the total organization and the much longer timeframe or comparison. Because during that period, there's a lot of noise, including COVID, pre-COVID, etc, etc. We elected like last time to show you a much longer time period. And we've looked at the 21 months that we've been -- that new management team has been here compared to the 21 months which is the period before that.

So quickly as I read which ties back to some of the principles that we've talked about in the previous slides. So we reduced the number of reps about 11%. Even though the tenure was down about 10%, the revenue per rep went up 23% roughly. The number of units declined, but in totality units per rep are up due to the tenure and the mix and some of the attrition that we have. And then some additions in the cash channel. And from the rental channel, which also comes through DTC, units are up 36% -- 36.6, and the units per rep are up 53.4%. All while we took the price up 21.3%. So not a different story along the time series reflecting back in terms of some of the disciplines that we've demonstrated the good scale before.

So let me now transition a little bit to the prescriber sales organization. So just by way of background, this is an organization we stood up in March of 2022 (ph). So it's relatively young in terms of tenure as an organization. Part of it was some of the learning and reapplying also in terms of what sales skills and what discipline and call frequency and call back do we need. Nevertheless, when you look at the results, they're relatively similar to DTC in terms of opportunity to scale and deliver role.

So I'm going to click through some of them, the number of reps went up from 34 to 54. Now within the 34, the focus and the funding and the data and the processes were not there. So that's part of what you see in the number. So number of tenured reps were down about 60%. But despite that, units went up 51%, units per rep went up 1.3%. New prescriber acquisition is up 75%, which is very critical if you want to cover more people upstream, you have to go to the prescribers. Patient rentals from existing prescribers went up 52.6%, and then from the new prescribers went up 94.2%.

These are very promising indicative numbers that say that prescriber channel which is upstream where people are diagnosed, prescribed, and put on therapy, if we get there and we continue with the progress, and by way of background, what we've talked about in Q4. So we delivered 23% quarter on quarter in terms of growth in that channel. And it's very critical for us to continue that momentum because it also fits where people get diagnosed, prescribe, and they buy in demand upstream versus only waiting for them downstream.

Before I go there, so just as a reminder, in the summary, the three channels are critical for us, including the partnership in terms of B2B, the balancing within those channels and where we direct our sales investments is very critical and important for us, and the prescriber channel is becoming much more prominent than it used to be because of the ability to scale and deliver profitability over the medium and long term in the end.

So that's a little bit on the commercial update, because there were a lot of interest in terms of give me a little bit more detail about what's really happening and where were we -- where were the things that we needed to jump over, why the change, why now, and how it would play out. But with that said, that’s behind us.

Let me focus a little bit on growth and innovation. It’s the lifeblood -- innovation is the lifeblood of any organization. And one of the things before I go through the slides that when we came to Inogen about two years ago, there was an innovation pipeline that once we applied the stringent criteria, you've heard me talk before about four criteria basically, that you applied to be able to evaluate innovations and the prospect of putting those in the in the pipeline. The first one and the most critical one, the clinical value. Can I actually have clarity on the patient population and with the indication and can I deliver clinical value is the first criteria. The second criteria, can I build the product? So technical difficulty. Third one, of course, is can I get it cleared by the regulatory bodies, FDA and/or BSI and/or EU MDR? And then, fourthly, can I get reimbursed for it? Because only cash sales does not generate the growth that you require, you need critical mass and scale.

And when we applied those four filters to what was in place at that time, and the pipeline, not a single project survived the criteria. So we had to start from the ground up one more time. Now, within that,

we've made significant progress. But let me start a little bit with what we wanted to portray the patient's needs and all the disease states or states plural.

So as you can see from the middle of the slide on slide 14, so hypoxemia, hypercapnia, dyspnea, and reduced exercise capacity are sort of intermingled. Like we used to sometimes for simplification you think of them as a disease progression. I start with dyspnea, which is shortness of breath and I progress. But in reality, when you look at the clinical pathways, sometimes things happen before each other. No matter what these four things are intermingled within the patient and the comorbidities are aplenty within them.

Now, if I look at the outcome, forget what the disease space, so these people can either have COPD, congestive heart failure, and/or obesity, leading comorbidities and indicators. But no matter how I look at it, there is an impact on the patients. Let me start with the patient's first. Restricted activities for daily lives. If I have dyspnea or if I have COPD it's the same, and sometimes if I have both, it's even worse. Exacerbations that lead to hospitalization, like we talked before. As a reminder, 1.3 million admissions into emergency rooms because of exacerbations in 2019.

Hospitalization and mortality. So there is patient impact on daily life and then there is both a clinical and an economic impact on the healthcare systems. And the reason we look at them now differently than looking singularly at COPD. So we were very focused in the last 10, 20 years on COPD. And there's an overlap in the patient population would want to show what the overlap. There are multiple comorbidities in the same patient depicted on this slide. They are treated basically within the same code points that we have for COPD. And then you can say, okay, pulmonologist and possibly cardiologists, basically are the two core points that within our universe of core points, I don't have to call on other people to be able to treat different disease states. And then like I said, there's a significant clinical and health economic impact on the healthcare system.

So keeping that in mind, that life for us is beyond only COPD, which is a change, moving forward. Let me maybe start with the portfolio lens first. So the view -- and the reason we're starting with that first is we had shown this in multiple meetings as of November all the way to JP Morgan. And I'm going to start with that just to remind us of what we started talking about and how we're going to now apply it to the disease space.

So the left side, which we're not showing, there's 20 years of POC leadership, so we're not going to worry about that. Let me focus on the '23 to '24 range first. So late '22 and '23 two product launches that are very important Rove four and Rove six, which are -- one is launched in Europe and the other one is going to be launched in the US. But we've talked extensively about that. From an innovation perspective. So what's in the pipeline for the next two years, this year and next year? A POC with more than six settings,

which is really important. And then pulse oximetry interoperability. I should be able to read the blood oxygen level -- the oxygen levels in the blood of patients to be able to pay it off moving forward in terms of how these patients manage their disease and how the clinicians take care of them.

And then when I look at the indication outside COPD, there is no dyspnea, shortness of breath. So COPD plus dyspnea. Then when I moved to the next slide, which is '24, '25. You can see that okay, the POCs will be added to ambulatory ventilation system, very important for people with dyspnea and hypercapnia. Hypercapnia being the accumulation of CO_2 in your bloodstream. The ability to just add ventilation to it and not only oxygenate the patient is really essential for you to manage your disease state. We will keep the pulse oximetry interoperability and then we will add a connected stationary concentrator because people are intermittently on POCs or stationary concentrators or tanks course. And we want to be able to monitor them no matter what modality they're on as long as they're on the concentrator not on a tank.

And then in '25, '26, a little bit further out. Innovation program continued slow and pulse. Continuous flow remains one of the things that some clinicians remain very focused on and despite all the efforts that we will do in terms of market development and POC-based therapy is adequate. Of course, you have to follow with all also from a portfolio perspective. So that's in the pipeline. Higher flow POC for patients with more advanced disease states, including COPD, need higher flow, in addition to ventilation which is in the previous stage. And then managing respiratory anxiety is really critical. Now the trend that cuts through these. We've talked about this before, we used to say there's a device plus strategy. So not only the POC and/or POC is ventilation. The connectivity of that device, but more importantly, what do I do with it.

If you want to start with the end in mind, the end is to be able to accumulate data. So remote patient monitoring, data accumulation, in terms of being able to base off in one of two ways. I can help the patient in terms of make decisions ahead of time. So I think the burden of them in terms of worrying about what's sitting on my on -- what's my blood oxygen level, all the way to closed loop, meaning if patients have them, I can change the setting and then inform them later. And then for the clinicians when somebody shows up once every quarter, so four times a year, I see them for 10 minutes, I have enough data in terms of trends, I'm not going to be buried in a mountain of data, to be able to look at it and say, I know how you've been doing, and I know how did I treat you, how to treat you, or what am I going to put you on in terms of therapy additionally to what you're on. That's data driven, and today that's nonexistent. So that digital help will cut across COPD, dyspnea, hypercapnia, and obesity like symptoms.

So that's a pure illustrative portfolio perspective. We started the conversation about the disease states that we are focused on, so hypercapnia, dyspnea, COPD, and then congestive heart failure. So let me

show comparatively. And this is also illustrative, but based on the numbers that we have. So all the sizes of the bubbles are comparative to COPD. So let me maybe illustrate with an example. When I look at the dyspnea, number of patient population is 219 percent the size of COPD today.

Now today, we don't play in that space. So I'm using this as an example illustrative to say, okay, how do I read this. And then the orange bar is basically the penetration of long term oxygen therapy. So let me look at the orange bar across first. So in this in these disease states, there's plenty of room because long term oxygen therapy has been penetrated enough. But we don't want to only play with COPD , want to play on the other vertical. But within the disease -- the main disease states, there are overlaps, like we were talking about and they are very important. So COPD and congestive heart failure, comorbidities in some of the patients, and you can look at the size of the patient that have both of them, but they're basically within the same therapy regimen and the prescription.

And then you can look at dyspnea. Dyspnea and COPD have an overlap. Dyspnea and obesity have an overlap also. And then hypercapnia. And of course, I'm going to point out, these look like tiny market sizes, but they are very high value patients in terms of the impact of hypercapnia on both economic and clinical meaning in terms of morbidity. Really high, hence there are very high valuation.

So let me take the previous perspective that we had the portfolio and overlay it. And you can see that what we had on the illustrative blueprint in terms of POC with more than six setting, CO_2 interoperability, to understand CO_2 level, and portable oxygen, portable continuous auto and connected resources serve COPD and dyspnea. All that first sort of like left hand side of the chart. And then the digital health cuts across. But then once we get into dyspnea, into hypercapnia, ventilation becomes important for us, which was in that middle of the of the portfolio chart that we showed you before.

So now you can say okay, Nabil, this is great. I actually liked this chart. But tell me, can you guys -- do you have the right to play in that space? And can you really win? I want to just go through two lenses very quickly to say, why do we have a firm belief that this is the right innovation strategy that could lead to growth?

So let me start with the project feasibility. Do you have the right to play? I mentioned four criteria before: technical, regulatory, reimbursement, and commercial. So of course, we're in COPD in the full market. So I'm not going to talk about. But if you look at dyspnea, as well as with the combination COPD and obesity, you realize that from a project feasibility, there is a lot of opportunity for us to play. And these have evolved over time, as you see of these variables and continue the progress is through the product development funnel, they will change hopefully positively, they become more full, or sometimes because of attrition, you have to actually abandon one of them. But from a right to play our code, they're

very close to oxygen therapy, there are patients that we know because they're similar to COPD, and they have the comorbidities that are together.

From an ability to win, the simplest best way to look at this is what do I do for them today if I don't evolve versus what do I do for them if I deliver on that innovation pipeline. And I don't need to actually talk through this, you can quickly see that the clinical value for these patients is different and significantly different between if I don't evolve as a portfolio and if I roll according to that blueprint. Immediately, you can see these Harvey balls filling up because you need that ability not only in oxygenation, oxygenation, ventilation, remote patient monitoring, and connectivity. And then your ability to win becomes much more significant as it's not only the devices evolving, but also the digital services within it.

So I'm going to go through with my summary in terms of why Inogen in addition to the fact that in my mind, these are patient populations and disease states that really still require a lot of help and there's a lot of runway in it. And so we have a global footprint. Of course, we're now improving our innovation pipeline, as demonstrated, and it's going to go beyond COPD. And the transformation we're building a scalable organization that actually not only from a portfolio perspective, from a commercial go to market perspective. The transformation is well on its way in terms of do we have the right teams and the capabilities and the right ability to fund growth moving forward.

And I will say one thing that I wouldn't put on the slide, back to the team that is in place today. So if you look at the last eight quarters, we actually have met or exceeded the expectations of the analysts seven out of eight quarters. And the only hiccup was in the last quarter and the miss was 1.4% below. So despite the fact that we were building and we're fixing the organization during the most turbulent times from a headwinds, in terms of the market forces, macroeconomic, supply chain, the some of the self-inflicted wounds from 2020, about MDD exploration, et cetera, et cetera, we delivered seven quarters, and we're back on track for the 2023.

And then the opportunity to return to profitability. In the medium to long term is a very different change from what we've had before, but a plan changed. We had said that the first year 2021 and 2022, were going to be investment years. This is the time now for us to actually add a lens to with -- instead of only focusing on growth, focus on profitability. And then the leadership that is in place, as well as on the board, the skills that are required in terms of leaning in and helping the management team get to the right place.

So again, as I said, when I started, there's about 1200 people at Inogen and they take the purpose very seriously. And they put the patient at the center of every day when they come to work. And this is something that is the glue that holds the organization together, motivates people to do the right thing,

and it is also the underlying motivation are some of the progress and the excitement that you see on behalf of the management team that we can become a larger, scalable, and more profitable organization moving forward, serving a larger number of patients, not necessarily only in COPD.

With that said, we're going to conclude the presentation part and then take some questions.

Operator

Thank you. We'll now start the Q&A session. For phone participants, if you'd like to be placed in the question queue, please press star one on your telephone keypad. Web participants may type your questions into the ask a question feature on their screen. We ask you please limit your questions to one question and one follow up, then please return to the queue. Our first question today is coming from Mike Matson from Needham & Company. Your line is now live.

Mike Matson

Yeah, thanks. Seems like you have a great plan and strategy in place. So good to see all that. I guess, you know, the stock has kind of suffered here a bit. And, you know, I don't know exactly what the issues are, it seems like the revenue growth has sort of been okay, considering the supply chain. But, you know, profitability has definitely taken a turn for the worse. And I know you kind of addressed that, but he didn't give any kind of longer term, you know, growth targets or margin targets or anything like that. But can you maybe just talk about, you know, when you expect to get back to profitability and positive EBITDA?

Nabil Shabshab

Yes, Mike. Thank you. I'll take that first. And then Kristin can comment. There's so many more details. So let me go back to I think the premise. So we're focused, like you said. We've delivered, as I ended my comments, for seven quarters out of the eight, and the eighth was a small miss. The delay in terms of the outlook moving forward, we have commented on our earnings call and prepared remarks that we will be low to mid-single digit growth in 2023 with an objective to get back to positive adjusted EBITDA by the end of the year. Now to the comment about our margins actually are worsening. And maybe Kristin can make a few comments in terms of once you start taking out the onetime events of the Fed, including PPV, and so on. So Kristin, can you make a few comments on that just for clarity on the margin impact?

Kristin Caltrider

Absolutely. Well, in Q4, we had a significant impact. The biggest impact really was coming from our channel mix, as the DTC was lower than normal and the B2B growth. So that that channel makes the biggest impact. But then, as you know, Mike, you know, the premiums that we've been paying on semiconductors, that has been a headwind all year long. And we do expect that to continue into next

year, but to begin to bleed off in the back half, so you'll see the margin expansion as our channel mix normalizes again, and as the PPV bleeds off the back half. Additionally, in Q4, we did have an increased warranty expense which drove down the margin as well.

Nabil Shabshab
So Mike, let me just add a couple of things just to quantify. The premium price paid for semiconductors, roughly 24 million for the year. And that's a significant headwind that is starting to improve like we addressed on the call in terms of supply chain. Some of it because of the pre-purchases will carry through 2023 in terms of what we'll have to spend. But at the end of it, we are hoping like everybody else, but this will normalize and then that guy on the P&L will go away.

Now, the remainder, Kristin explained. Let me tie it back to when she started the comments with. It's the channel mix. If you reflect on the discussion we just had, there's a reason behind optimizing that channel strategy moving forward, as evidenced by moving away from a yardstick of DTC is the only and the best way to measure the success or failure of Inogen. But when like we sort of showed the scorecard that is partially true. But also, if you want to mind getting back to profitability, which is at the core of your question, that optimization in DTC and the evolution of the prescriber channel is really critical for us moving forward. I hope we've answered the question, Mike.

Mike Matson
Yeah, that was very helpful. And then just as a follow up, you know, the channel mix, you know, point that you're making. I guess, can you just comment on, I mean, the gross -- clearly, we know, there's big differences in the gross margins? Can you maybe just comment on that? I know, you're not probably -- you're probably not gonna give us numbers. And then, you know, what about the operating margin differences across the four main channels? I seem to remember the prior management team would say that they weren't that different when you get to EBITDA or operating margin. But, you know, can you just remind us there, where's the -- which is the most profitable channel on that basis?

Nabil Shabshab
Thank you, Mike. So let me maybe start at the high level. What you saw on the slide in terms of the contribution margin, if that is a proxy to answering your question. At scale, the prescriber channel is going to be very profitable. Today, what you see with us -- what your visibility is, you see gross margins on the rental channel, which is very healthy. And then you see a gross margin on sales, which is both B2B as well as DTC.

But for us, if you are going to scale an organization and get back to profitability, we have to go beyond the gross margin. As I said before, the DTC channel is an expensive channel that continue to maintain and scale because of the advertising spend required for you to generate that growth. So it doesn't mean

we're going to walk away from it, but I want to optimize it. If you say, okay, give me an answer, which is the most profitable channels, my trajectory in terms of thinking about this prescriber at scale will be the most profitable channel over time. That's why we're spending our energy and time and investments there has to be the most profitable channel moving forward.

Mike Matson
Okay, got it. Thank you.

Agnes Lee
Okay. So I think we can open up for questions here in the room. And I know Mat had one, so why don't we start with you?

Mathew Blackman
Thank you. A short term question and a longer term question. Appreciate all the color on the strategy, on optimization, I guess the question I have is again in the shortest term, why is six months the right timeframe to think about this turn is a pretty steep first half or second half acceleration in productivity. Why is that the right timeframe? And then to the extent you can talk a little bit about the long term, what are we shooting for it steady state here? What is an ideal salesforce size in terms of scale and productivity of rapid? Just, you know, what's the ceiling? What could this be in your mind if you do execute on this?

Nabil Shabshab
Perfect, thank you, Mat. Two great questions. So let me start with the why six months, because it's a -- it's an excellent question. So if you reflect on 2022 and how things played out during the year because of supply chain issues that we had and then the surprise is on MDD and the EU MDR. We had to prioritize DTC, the revenue number, because naturally, the highest ASP, highest margin. So we didn't pilot much in the first half of the year, because that was not -- no time to tinker with that organization, as the priority was get the most revenue you can for the supply available.

Now, as we shifted focus, and sort of Q2 into Q3 into remediating Europe for MDD and then later on remediating the backlog in the US, and because we were still supply constrained, especially in Q3, it was time to start the pilots and ramp them up. Now the pilots did not ramp up as much as we wanted. So they took Q3 and Q4. Now, naturally part of what we've shown in terms of what are the variables that we've isolated to be able to focus on. Some of it is behavioral and sales discipline. It would be foolish on our behalf to say I can completely change behaviors in three months and a quarter. Now we believe that the impact will start showing up in a quarter, extending to two quarters because this is not like black and white, Mat, or flipping a switch. There is discipline, sales, behavior, time management, these are things that now we know exactly where the potential friction is and how to solve them. But they are reliant on

people changing their behavior. And we know that we will drive that lead about three to six months instead of half first and second half.

So that was the first question. So ideal mix in terms of or ideal salesforce size. So let me start with historically. We have recently made promises -- we're about 300, and we'll say give or take 10%, 15%. We've made comments in the earnings call that we are now at 250 trending south of that by the end of the year. We believe that the productivity will play out in terms of what the smaller salesforce with an optimized advertising ,that call into the objective of productivity, efficiency, and profitability. Eventually the medium term will be 250 trending south. We will update people as we go. But there is room for us to continue to optimize. That's on the DTC side.

Let me just call it the prescriber. Prescriber we stand at around 60. We believe there's still a little bit more room and the rationale there is relatively simple. We looked at the universe of targeted prescribers want to call on. We look not only at coverage but frequency in terms of the highest decile. We believe the number is between 60 and 75 over the next year or so. So that's the right numbers to think about from the outside salesforce versus the inside salesforce.

Does this answer the question, Matt?

Mathew Blackman
Yeah, but anything on productivity, what you think a productive rep should be generating?

Nabil Shabshab
Yeah. So we showed historically -- that's a great question. We will be updating productivity metric once a year moving forward. And we want to clean up the periods. The reason these periods are long and they're a little messy is because there was, like I said, we didn't change that much in Q1, Q2. We started changing Q3, Q4 There was COVID in the middle of it. So we use these time periods to make sure that we are very comprehensive. Moving forward, we'll compare year on year and at the end of every year, we'll look at productivity numbers. And we are confident that the productivity numbers will be much more positive than they are today.

Brett Fishbin
Can you provide a bit of an update on how you're thinking about generating some clinical data that demonstrates the advantages of oxygen therapy and specifically POCs. And like, how much of a priority do you think it is as you look to expand the base of prescribers and eventually expand to some of the new indications as well?

Nabil Shabshab

Yeah, let me make the high level comment. And Stan will actually -- is the expert, it's his baby in dealing with this, but let me start. So in our prescriber channel. Today, if I look at the low penetration rate of POCs, it's not only products and service, it's also involvement and conviction. So let me call the involvement and conviction. If I'm a prescriber, that today is prescribing two liters per minute agnostic of modality, you're going to have to convince me, not only through clinical data, but also some positive key opinion leader interactions, to be able to say, You know what, I need to spend a little bit more time prescribing the right modality. With that said, I'm going to let Stan make the rest of the comments.

Stanislav Glezer

Thanks. So maybe before we go into what's going to happen in the future and how we're building, let me just start with the foundation as to where we're starting from, right. So generally speaking, the oxygen therapy is supported by few studies, not that many. And typically, they do not differentiate between neurons. So even if you look at the current guidelines, there's just you know, a mention of saying, well, ambulatory oxygen kind of makes sense, because people can move with this, but it's not like, you know, it's a robust set of evidence. And the emphasis in those studies is really on the influence of reducing mortality and morbidity.

Therefore, by default, you're going into various sick patient population literally at the end of their journey. So what we are trying to do while continuing to anchor ourselves in the current guidelines, recommendations physician we're trying to say well, actually before patient gets there, they are becoming short of breath, and the way they manage it, they are limiting their activity, right? So there is direct impact on the quality of life. And once you stop moving, all the bad things start happening.

So the way we're trying to approach it is we're trying to move into saying, okay, why don't we look at the specific impact of our devices, whether there's a current portfolio when the oxygen -- portable oxygen concentrators, or the development devices with the portable ventilatory assist. To show that this is actually have -- this has an opportunity to change the way people function, right. So this is one avenue that's where we see.

The second avenue that we're looking at, coming back to the slide that Nabil was showing is, well, if patient has overlapping conditions, such as, for example, COPD and congestive heart failure, or dyspnea and obesity, right, they are much -- but they have much higher propensity to need the support. So why not go into those conditions and look at the overlaps and generate evidence.

So those are a few avenues that we're going to pursue in terms of filling the market and also building deeper evidence in the populations that we're targeting. Now, before we put any strong investment into, you know, conclusive pivotal studies, we need to make sure that we are shooting for the right targets, right. So therefore, what we're doing right now, we're putting efforts into epidemiological observational

evidence in terms of how patients are managed and what the issues that they're facing, and also into these smaller pilotized studies.

So it's not a huge fan, it's a quicker turn around in terms of in and out to get the evidence, but that should allow us to put the bets on the right goals when we're committing to the larger trial. So we're currently in the pilot phase and observational phase. Next way will be maybe a couple more selected approach to the more conclusive larger scale trials.

Nabil Shabshab
And Stan, just in 2023, what do you expect to accomplish? Provided is a little bit behind and people are not publishing on time, but just give them an idea of what we're publishing.

Stanislav Glezer
So from the real world evidence perspective, there are two sources of data that we are currently looking at. And we should have the reports from them this year and publication one is we actually have access to the French Ministry of Health data set that looks at the targeted patient populations and the modalities of treatment. So we have it for the whole country.

And we also looking at our own device generated data. Keep in mind though devices report to everything that happens to them, by the minute from the moment they're being produced. And we do know our patients pretty well through the call center and support to reimburse train. So we're looking at the patterns of use, we're looking at the adjustment of settings, we're looking at the respiratory rate, all of those things to kind of understand where was that?

So those are the two observational efforts that will generate data. From the clinical study perspective, we are -- we have completed the low quota study, we're expecting the preliminary results, and maybe two to three weeks from now. We are starting to study in heart failure. Looking at the improvement capacity. We are starting a sleep study showing the ability to titrate patients on the pulse dose to reach the target levels of saturation overnight. And later in the year, we hope to do the study or to start the study with the ventilatory assist to improve and assess capacity.

Unknown Speaker
Speaking to your change, allocate the marketing budget by channel. And then whether there's been any change in messaging to deliver higher quality salesforce. Secondly, historically you estimate CAC is as low as 200 before they did the big ramp for salesforce in 2018 from '19 high 600. Now about 400. What is in your mind the acceptable goal stop line? If you spend greater than 400 CAC? No, it's a 300 CAC that we're going to spend against and if we go against, we stop spending, or we stay below it then we keep spending. Or what is that assessment?

Nabil Shabshab
So let me back up maybe if people didn't hear the question fully. So what are we doing in terms of lead generation and optimization of that effort?

Unknown Speaker
Or the messaging.

Nabil Shabshab
And the messaging. So there's multiple efforts within that. One is on the omni channel. So what's the mix between teams, DirecTV, Omni channel, social media, etc, etc. And then within that, which ones actually generate more phone leads versus web leads are very important for us. So there is room within that the quality of the leads that we get in terms of qualifying them before we put them into the sales funnel is important.

And then on the back end of it, as they go into the sales funnel, if they don't close immediately, what's the nurture path in terms of putting them back into a marketing funnel where you continue engaging and then try to sell them one more time. So those variables are going to lead, we're not commenting in hard numbers in terms of advertising spend, as we click through the portrait, you're going to see that we're optimizing advertising spend to be able to get to that productivity efficiency and higher quality marketing funnel view. Then the hard work starts in the sales funnel. Now your question is on the size of the salesforce also --

Unknown Participant
No, no. So the first part of the question is, are you -- is there significant changes in how you're allocating the ad spend budget? TV, social, SEM, SEO? And then is there any change in the messaging? Believe that you will deliverable -- how you allocate the budget by channel, messaging, or is it generate oxygen.

Nabil Shabshab
So the first part, there is a lot of work on what the channel marketing mix says, like I said. Okay, Direct TV, long form, short form, social media, etc, etc. The focus is to generate more phone leads as much as possible over the web leads and the high quality. Now, within that the messaging, now we understand, because we did a segmentation study on our patients, as well as prescribers. We know the four segments exist in the market.

The messaging in general will be tailored to the segment type. So when you get into the funnel, we're going to designate which patient segment you're in and your sales messaging other than the value proposition and how do I present that sales to value proposition, the sales manager messaging is tailored

to the segments to improve the productivity of the salesforce. Lead to a shorter sales cycle, and a higher close rates and within the messaging.

Now, overall, the creative so far, we haven't done anything on our creative. The next phase, you've indicated what it is, based on all these insights, we are going to refund our creative. 2022 was not the time to do it. But moving forward, new creative that will be produced to get on social media and on Direct TV will be informed by all the insights quantitatively that we gathered about the patients, and which segment is more important than others for us to maximize the return on investment from a marketing spend.

Unknown Speaker
What's the level of CapEx? Red light or green light? You spend above this, you stop? Do you track below this?

Nabil Shabshab
Yeah, we're not going to comment specifically on that number. But we will consider it as part of the metrics to actually report on.

Mathew Blackman
Question on the pipeline, talking a lot about remote monitoring. Is that something that physicians can monetize? Is there a reimbursement for that? Does that still has to be put into place? And then the follow up is you have that spot with the right to play pie graphs where, you know, there's still some white space? So when you think about what you need to get to the medium and the longer term innovation. Is it humans? Is it technology? Do you need M&A? How do we fill in those remaining spaces?

Nabil Shabshab
We'll tag team on that. Let me answer first at the high level. So I think, let me start from the back and then work my way to the front. The pipeline we showed is organic. It's within our capability. Stan can make a few comments in terms of which one is the biggest difficulties in technical and/or clinical in terms of evidence, and so on. So it's organic. And I think it's important for us to think about that pipeline in terms of predictability, can I deliver most of these programs, and we know innovation, there's an attrition rate that is inherent in the pipeline, because the thing is to look at this pipeline, and it has multiple opportunities in it. And even within attrition, there are projects below what we called below the water line in terms of funding today. And then you can replace one project for the other. From a funding perspective, we're comfortable funding all the projects in the pipeline today, with the exception of maybe the back end of it for the length of it, because we're managing our expenses judiciously. But those are in the '25, '26 window. I'll let Stan make a few comments on the quality of the innovation pipeline.

Stanislav Glezer

So on the innovation pipeline, maybe to qualify it, we have assumed certain attrition rate. And we have purposefully put more projects into the pipeline so that, you know, we compensate for it. And we can deliver a steady state of things coming out over the next three to four years. And we have also diversified the innovation pipeline by the level of risk and by the type of project. So we have the physical devices, digital health projects, and the new indications of uses. Right. So different things to different risks, you know, different timelines. From the perspective of the capabilities on the slide that the Nabil has shown you might see some of the Harvey balls being half empty. But that's not from a technological feasibility perspective, it's just that some of them being a little bit more innovative than the other is we still need to consult with the regulatory agencies in terms of what is the right path and strategy to actually get it to clearance because there are multiple options in front of us. And we just need to weigh what's the most advantageous way to proceed.

From the perspective of reimbursement and coverage that you asked about whether physicians can monetize digital health. There are established reimbursement codes for the remote patient monitoring and for telehealth, telemedicine. The way we are approaching it is that we plan to leverage the existing codes and make sure that the profile of the product fits into this. But that being said, you know, that is also synergistic with their approach to the prescriber channel because they will not update it naturally, right, you need to actually talk to them about that opportunity, describe the product, and make sure that it's raised well with the EMR screens or whatever it is that they're using as their main systems.

So this is where the efforts are going to go into in terms of making sure that we look at it as an opportunity. But last, but definitely not least, aspect of it that I wanted to highlight, some of it is directly monetizable through those codes. Some of it is monetizable through the opportunity to differentiate the product and update share because of the patient value. I would like to reiterate that we're dealing with the chronic progressive conditions where adherence to therapy historically have been problematic, and the individualization of therapy has been a challenge. So allowing patients to see how are they doing is allowing to identify areas where things are not going well importantly, intervention, have an opportunity to one, optimize the patient use of the technology, two, allow for the clinician to intervene at the right moment, and then the for the combination of those two, hopefully, you know, open the promise to improve the patient outcomes.

Nabil Shabshab

So just maybe also directly to your question, Mat. So we know what the reimbursement codes and the values are. There are like four, three or four of them for remote patient monitoring and respiratory, respiratory distress. So the model from a monetization perspective is not only the clinicians to pay it off in terms of quality of care and for differentiated devices. You can charge that service at a lower fee and reimbursement allowing for also a monetization for the clinicians themselves to be able to get

reimbursed for the full amount when the cost of the service is lower than that. So that's the other business model. And it's various business orders like that today, not within Inogen, but established business model.

Agnes Lee
Okay, any other questions?

Unknown Speaker
Nabil, can you switch into the sales aspect of describe what changes have been made through the profiling the right candidates, talked about sales up, but if you could describe what was changing the trending in sales and describe changes in your ability to retain (inaudible) recruit, train, retaining.

Nabil Shabshab
So it's a great question. So we're in 2022, we upgraded not only the criteria in terms of who we want to attract, how do we qualify them, and how do we onboard them first, but then now the programs are moving, how do I train them for continuous productivity and for retention? Which is the second part of your question. Part of it is we're considering not only that, but also remission (ph) plans. How do we like think about that are part of the what's being implemented right now.

There is a tenure issue that sort of was part of the performance in 2022. We believe couldn't be partially part of the performance or keeping people for a longer period of time is important. But we've also realized that the tenure is an important criteria, but not as important as the other criteria that we've shown. And if I gave you the right system, the right data, and the right accessibility to win and the process plus the coaching and continued development, tenure matters less. One of the things we did not show, there is now evidence that we have that people with lower tenure are almost producing close to the people with the highest tenure despite the recency --

Unknown Speaker
-- So you are in the process.

Nabil Shabshab
Yes. So we didn't put that in the slide, it's too much data, but people that have been here about four to six months are getting close to the productivity of the people that have been here longer. So that's part of the playbook moving forward.

Unknown Speaker
What is the right time for CSL to own salesforce because maybe get better control, you could run into productivity, etc. etc. And then describe before the clinical efficacy is there, what value proposition is

there, because today they have (inaudible) and they're filling us with the case managers, many oxygen providers. So without clinical evidence, why is a doc -- are they even gonna put you on a list of other oxygen patients?

Nabil Shabshab

I think two excellent questions. Let me maybe back up last one first. The first -- in addition to your portfolio being compelling, and I'm going to draw your attention back to what patients want when we showed those quantitative numbers. Patients really want to be on POCs. So if they're given the optionality. Now, the optionality is a frequency and presence issue. So not only how many prescribers you cover. With what frequency? How many times you show up in a month? Becomes really critical. Because the way the process works, the prescriber is actually issuing these prescriptions on the back, the front office staff is handing them out, like you said, to HMEs where one of the HMEs. Now, when we go into the field, and we talk to permissions, people say everybody wants to be on a POC, I know the value of it, but everybody wants it.

Now, what you're trying to short circuit is that the transition between the back office and the front office two ways. One, if you're that convinced, write it in the prescription that you want POC, not only liters per minute. That's the clinical work and development, plus the education. And within that, we insist when we call on these prescribers that our salesforce talks to the prescriber, not the front office of the staff only. So part of the productivity measure that you get face time with a prescriber to tell them the value proposition.

Now, the good news is everybody knows the brand. Everybody knows the quality. And everybody knows the value of Inogen POC. So that was another advantage. But the frequency and the presence in those offices is really critical. And if you look at the coverage and the frequency, this is how we actually throw out these maps, because we want the right amount of frequency, not only the coverage, especially as you nurture these offices, like you said.

In the beginning, much higher frequency, once I get into that normal cadence, I'm getting my fair share of the prescription, and I'm delivering those of the service, you can lower the frequency and expand the market. That's the definitely frequency and frequency is as important as coverage.

Unknown Speaker

So yeah, so part of it --

Nabil Shabshab

The CSO, we have the optionality contractually to convert anytime we want. We're still now optimizing in terms of like there is sometimes the need for it. So there's a lot of analytics that come with the CRL.

And this is why we say we're much more data driven in our approach than others. So part of the CSO offering is part of analytics. we can isolate that over time and buy it separately. And then rebadge salespeople internally. And that's the vision when we started within 18 to 24 months, we're still in the first year, but it's definitely under consideration whenever we need to make that decison.

Brett?

Brett Fishbin
I just have quick follow up on the prescriber channel productivity metrics. Definitely I've noticed a nice uptick in the number of patient referrals for new and existing doctors. But the actual number of units per rep didn't change that much. Like how do you think about that metric specifically? And can you like, can you see maybe like a lagged inflection this year as the strategy gains momentum?

Nabil Shabshab
Yep. So good question, Brett. So let me maybe characterize it when there are two variables underneath that number. The number of -- so you're referring to the web platform 0.9%. Right? So there's two numbers underneath that. One is we went up in terms of the number of people that are less tenure and that organization. So you saw that unit productivity go down a little bit. And then there was some turnover just to be completely transparent. We had to retrain people that were not performing at the right level. So that impacted that, but then as you scale as the tenure starts building up on the prescriber side, because tenure is really important on the prescriber side for the relationships, much more than on the DTC side. And that is behind us. You're going to see that productivity climb up again. And evidenced by the number of new prescribers, we're signing up and then the number of existing prescribers too.

Brett Fishbin
Thank you.

Agnes Lee
I don't think we have any more questions on the line. Is there anyone in the room? Right. Okay, Kevin, you can go ahead and close the call.

Operator
Thank you. And thank you for attending Inogen's strategy update conference call. This does conclude today's call. We will be disconnecting the line. We hope everyone has a great day. Thank you for your participation today.