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Apollo Medical Holdings, Inc.'s Corporate Presentation
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Speakers:

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- Brandon Sim, Chief Operating Officer and Chief Technology Officer, ApolloMed
- Eric Chin, Chief Financial Officer, ApolloMed

Robert DiGia: Good afternoon and thank you for joining the 2021 virtual UBS Global Healthcare Conference. My name is Robert DiGia, and I'm happy to be your host for this session. Our next presenting company will be Apollo Medical Holdings, publicly traded under the ticker AMEH. Presenting today from Apollo Medical will be Brandon Sim, Chief Operating Officer and Chief Technology Officer, and Eric Chin, Chief Financial Officer.

A Q&A session will follow immediately after the presentation. To submit a question anonymously to be answered at the end of the session, please type your question in the Q&A prompt on the presentation screen. I'll now turn it over to Brandon. Thank you.

Brandon Sim: Thank you so much, Rob. Thank you, everyone, for being here today and listening to our presentation of our company, Apollo Medical Holdings or ApolloMed. If you'll follow along with me on the slide deck here, I'd love to move onto slide 3, which is our company overview. And thank you, again. Happy to take questions at the end of this and have a productive dialogue.

So on slide 3 I wanted to give a high-level overview of what the company is and what we do. ApolloMed is a value-based care company. We're a healthcare delivery platform that allows for doctors to quickly and easily onboard onto taking risk for their patient populations through capitation agreements and participating in value-based care arrangements with our over 20 payer partners, both national and regional in nature, as well as through CMS.

We allow for providers to do that through one seamless platform, serving as an intermediary and an enabler of the provider to provide the best quality care to their patients, while lowering total cost of care possible in the healthcare system. We've done this profitably for over 20 years now. And although we're fairly new to the public markets—I believe we up-listed in an IPO in 2017—we've been doing this privately and profitably for a long time. So we've got a track record of managing risk profitably and enabling doctors to do value-based care profitably.

Brandon Sim: We've got this down to a playbook that's both repeatable and scalable, and we have an industry-leading technology platform backing that up that helps with clinical decision support, as well as back-end automation efforts that are driven by a huge data moat that we've accumulated by doing this for so long.

This flywheel effect of a large provider base and an ever-growing provider base really, as well as industry-leading technology, allows us to be a leader in a very, very rapidly growing space in value-based care. Nationwide, there's been a huge tailwind towards the drive to value-based care from a fee-for-service based traditional reimbursement model, and we're really at the forefront of that. We enable providers to take control of how they're treating their patients and align their financial incentives with the patient outcomes, thus giving them the tools to succeed in value-based care arrangements and lower total cost of care in the healthcare system, while improving quality of care provided.

So that's at a very high-level overview of what we do. As Rob mentioned earlier, we are traded publicly at Nasdaq AMEH, and we look forward to presenting the story today. If you'll move with me to slide 4, I wanted to set the table for why now, why are we important, and what are we even doing to herald in a new age of value-based care.

Many of you may already be familiar with some of these metrics, or some of this information. But traditionally, providers have been reimbursed in the United States under a fee-for-service volume-based type of reimbursement scheme. And so in this scheme, in this reimbursement mechanism, doctors are reimbursed based on the quantity of services they provide, rather than the quality of the services they provide. They are paid proportional to how many visits they do, how many things they prescribe, etc. And so there's really a lack of incentives for doctors to improve chronic conditions, to lower medical costs, and to better treat the patient in a way that prevents them from having to have so many services provided to them in the first place.

The U.S. healthcare landscape is really rapidly moving towards a value-based care system, and we've seen that both in terms of alignment in terms of payer models, through innovation models from CMS, the Center for Medicare and Medicaid Services, as well as in recent public market activity in this space. In a value-based care model, providers are incentivized to improve on the general health of their patients, rather than optimize for quantity of care provided. And that leads to alignment both financially and clinically for providers. As you can see here, America is still on the path moving towards value-based care. COVID has obviously accelerated that, as it has with many other trends. But ApolloMed has been serving in the value-based care space for a long, long time.

Brandon Sim: If you'll move with me to slide 5, providers also know this. Physicians, when they were surveyed by the American Medical Association in 2019, 88% of them said that the recognize they will need to adopt value-based care models. However, also a majority of them unfortunately said that they don't feel successful -- they don't feel equipped, rather, to successfully navigate value-based care. They don't have the tools to report properly. They don't have the resources or technology to improve their quality while reducing risk financially for themselves, and they lack access to technology around displaying their clinical outcomes, showing actionable notifications for what they might be able to do to improve those clinical outcomes, and they have no visibility into what patients are reporting for their own outcomes.

And so although the country is moving towards value-based care, although physicians recognize -- an overwhelming majority of physicians recognize the need for value-based care, they don't feel equipped to succeed in that potentially complicated structure. And so if you moved with me to slide 6, you'll see that this is exactly the need that ApolloMed exists to serve. ApolloMed is a pure play value-based care platform that empowers physicians and allows them to succeed in risk-based arrangements, value-based care arrangements with various payers, as well as in various reimbursement schemes under value-based care arrangements.

There are four key aspects that allow us to drive the success in the value-based care arrangement. One, we enable providers to successfully take risk by onboarding and giving them tools to succeed, such as technology tools on the front end, such as point-of-care tools, as well as technology tools on the back end, like workflow automation, billing and reimbursement and coding help, and other kind of related functions. We've proven the ability to do this over many, many years, both in our IPA segment as well as in our next-generation ACO program, which participates in the CMMI Center for Medical Innovation, which is run by the CMS program, that allows for us to take care of over 30,000 Medicare fee-for-service beneficiaries in a benchmark value-based care arrangement.

Secondly, as I alluded to earlier, we're driven by a leading proprietary tech platform. We've taken the 25 years of operational expertise that we've developed in managing risk and figuring out the right workflows and providing actionable notifications to our providers, and encoded it into a custom-built proprietary solution that's really industry-leading in terms of its capabilities. Like I mentioned earlier, there are point-of-care tools that we have. There are member-facing tools that we use, and there are back-end facing tools that are kind of more payer related in terms of processing claims automatically, looking at utilization, doing analytics on our population health.

And that really segues perfectly into the third main differentiator of the company, which is that we champion quality outcomes and we have a real

focus on population health. Our physicians and doctors and nurses are supported by clinical decision support tools, and we have a lot of nurse-led teams that are using our tech platform that I described to ensure that patients are receiving the best quality care while keeping total cost of care down.

Brandon Sim: And finally, all of this is enabled by our value-based care services department, which is our wholly-owned subsidiary Network Medical Management. That takes care of administrative functions such as claims, authorizations, checking member eligibility, as well as a wide variety of other administrative tasks in healthcare.

Moving to slide 7, I just want to follow the flow of a dollar as it goes through the system to better help understand where ApolloMed lies in the healthcare ecosystem. In a way, we act as a pseudo single payer. We take dollars from a variety of insurance providers or other payers, and then we enable doctors to quarterback patient care and really improve clinical outcomes.

We do that, like I mentioned earlier, through our tech platform, through our years of operational expertise, and through on-the-ground interventions with our nurse-led teams. We take those dollars from these variety of payers and pay them out to providers via value-based contracts, aligning financial and patient outcomes. And the dollars that are left over are also further shared with doctors to incentivize them with upside. And then the rest is kept at the ApolloMed level. So that's at a very high level how a dollar flows through insurance or payer space into Apollo, to the providers, and each step of the way we are aligning financial and clinical outcomes in order to ensure the best patient outcomes possible at a lowest total cost of care. It's this platform that we built out over 25 years that we've encoded with state-of-the-art technology that allows us to scalably add new doctors into these value-based care arrangements, and really grow the model in California, New York, and beyond.

If you go with me to slide 8, a lot of these relationships have been built over a long time. And it's very diversified as well. So we're not necessarily beholden to any one payer, as some of our competitors may be. We have over 15 years of average tenure with our key payer partners, but less than 15% of our total revenue comes from any one given payer. And so we have a very good relationship long term with 15 to 20 different national and regional insurance carriers, as well as with CMS, and we continue to use our technology platform to drive quality outcomes in those payer/provider relationships that we have.

Moving with me to slide 9 here, I want to illustrate a little further, because I think it can be confusing how the dollar flows in terms of how our unit economics are extremely attractive as well, and extremely predictable. So we are reimbursed by insurance companies, for example, or by payers, on

a per-member-per-month basis. That's that first blue rectangle there. We will pay out most of that into taking care of the patient. We'll pay most of that out to medical claims expenses or pay to the doctors through capitation or other value-based care arrangements. Then what's left of that is the gross margin, which is the third category there. There are also some operating expenses related to some of the back-end processing, which is handled by our Network Medical Management subsidiary. And what's left is kind of our EBITDA or bottom EBITDA margin, so to speak.

Brandon Sim: This differs from perhaps industry peers in three key ways. In the first box on the top right corner there, you'll see that our scale allows us to better negotiate contracts with payers, thus increasing the revenue per-member-per-month dollar amount that we're getting on the top line. In addition, these capitation revenues are normally risk adjusted as well, based on the risk presented by the members we're serving in our population, and our advanced risk adjustment technologies allow us to achieve better results there as well, as appropriate, of course.

In the second box, you'll see that our large network, our aligned network, our value-based care arrangements, as well as our care navigation tools allow us to really lower medical loss ratios relative to peers in the industry. That's allowed us to have more left over on the gross margin. And then finally, in the third box our tech-enabled management service organization, or Network Medical Management, utilizes workflow tools, workflow automation, and really kind of scale across our million-plus members to really lower OpEx as well from the MSO or third-party administrative side. And so at the end of the day, all that results in a much higher EBITDA margin compared to peers and is a really attractive and predictable unit economic model that we look to scale as we add more members and add more providers to the ApolloMed platform.

Speaking of scaling, I also wanted to introduce on slide 10 some of the levers that we really have to drive additional value, as doctors move onto the ApolloMed platform. And there are really a wide variety of levers here. I apologize if some of the text here is not quite as easily legible. So hopefully you'll be able to follow along with me as I speak about it. But that first bar there is increased capitation due to contracting power, negotiating power and risk adjustment, as I mentioned earlier.

There's additional levers we have to pull in terms of bringing on new service lines, new products. For example, looking into the commercial members, looking into employer insurance for example. The third bar there is association with the scale that we've achieved in our Network Medical Management subsidiary, lowering MSO fees through our workflow automation tools, through our scale.

The fourth bar there is our decreased medical loss ratio, as I mentioned earlier, through better specialty network management, better care

coordination and care navigation with our populations. And the fifth bar there is improved quality of care bonus realization in terms of value-based care initiatives or incentives that we're able to achieve because of the technology platform that we built out here, and the buy-in that we've achieved with our aligned physicians. And so all of these levers, there's more that I haven't put on this slide as well, lead to quite a large total improvement potential as doctors onboard onto the platform. Obviously we would share a lot of that with doctors, and kind of whatever is left will be net savings to ApolloMed as a whole.

Brandon Sim: And so kind of the story so far to summarize, is that one, value-based care is here to stay. Doctors know it, and there's going to be a rapid move towards value-based care in the years to come. Two, ApolloMed is a pure-play value-based care platform. We've been doing this profitably for over 20 years. We have long-term relationships with our payer partners that will allow us to continue doing this in a diversified fashion. And our unit economics are very strong, especially or even when compared to industry peers. Three, we're able to expand profitably as well. There's a lot of levers we have to drive additional value as we grow.

And now moving on to slide 11, we've shown that growth. We've proven that growth over the last three years, over the last—sorry seven years with a 20% year-over-year CAGR from 2014 to 2020. And we look forward to really consolidating now as the shift towards value-based care nationwide really continues, and planning to grow very rapidly in the years to come. So we've put out a very ambitious estimate of reaching around 2 million managed members by the end of '21, this year, as well as getting to around 10,000 contracted physicians, which would be around a 39% CAGR over the last seven years. So we've proven that model, and now we want to grow that.

If you move with me to slide 12, we've also proven our model in the next-gen ACO, which is a CMS program, where we take care of Medicare fee-for-service members. I alluded to this earlier. But we were the fourth-best ACO among published data in 2019, which is the most recent published performance year data for the ACO program, in terms of both gross savings dollars, which was over $37 million saved for Medicare, as well as gross savings percentage, which was around 7.5%. In addition, we did that at an above-average quality score, almost 96 percentile relative to the average of around 94 out of 100. And we've done this while we continue to grow the Medicare fee-for-service population that we've taken care of, moving from around 23,000 members in 2017 now to over 30,000 members in 2019.

We continued to participate in that program in 2020. The results have not yet been released, which is why I can't speak about them here. And we also continued in that program this year as well in 2021. We also look forward to rolling this program over into new CMMI programs, innovation

models, such as direct contracting in '22 and the years to come. And we think that our track record of demonstrated sustainable success in the next-gen ACO, as well as our ability to take risk profitably in IPA segments, really sets up well to succeed in these direct contracting models to come.

Brandon Sim: Moving on to slide 13, there really is a virtuous cycle or flywheel that drives ApolloMed’s growth now and in the future. And there are four key elements to this flywheel. One, as we get more providers, the sticky provider-member relationship will drive member growth. As membership expands, we’re able to further refine our operational processes. We’re able to expand the data moat that we already have against industry competitors, and we’re able to use that data to feed machine-learning models that only improve and scale with additional data. Better models, better technology, better operational processes lead to better outcomes. That’s been proven over our 25 years of operation. And better outcomes will increase both value-based care incentive payouts, as well as decrease MLR, and lead to a healthier population. That leads to more dollars that we can then share with our providers. And when providers get more dollars through our platform, they will tell their friends. There will be organic growth and more providers will join the platform in the first place, thus leading us back to the 12 o’clock position on our flywheel.

And we think this is something we’ve proven to work, we’ve proven out to work over the last 25 years, and we look forward to putting this in hyperdrive for the years to come. We’re going to be feeding as much as we can into every single step of this flywheel until we are completely nationwide and have passed our 2 million member mark for 2021 that we’ve promised.

Moving to slide 14, I’ve said a lot of things about what we do. I’ve said a lot of things about our tech platform. But how do we know that it actually works? Well, we also track clinical outcomes very carefully, and I’ve chosen – I’ve selected Medicare, which is kind of a segment that is very interesting to the investor community at large these days, which is the care of our senior, over 65-year-old, members.

Looking at Medicare and comparing to CMS benchmarks, as published by CMS in 2019, we have achieved 50% fewer hospital admits per 1,000 members, 55% fewer emergency room visits per 1,000 members, 22% shorter average lengths of stay, 1.3 days on average shorter length of stay, if a patient is admitted to a hospital, and 62% fewer in-patient bed days per 1,000 as a whole. That’s really remarkable, I think, especially as you look at some of our competitors’ data, which I've shown where they’ve actually published it. The platform has enabled demonstrable and sustainable improved outcome for members and that leads to both happier members -- no one like spending more days in the hospital -- as well as lower medical loss ratios, which allow us to have industry-leading profitability metrics.

Brandon Sim: Moving on to slide 15, a lot of this has been driven by our proprietary tech platform that we've built completely in-house with engineers here at ApolloMed at our headquarters. We use artificial intelligence, machine learning and natural language processing, combined with our 25 years of clinical expertise to really develop a whole set of tailor-made solutions that enable our workflows and give doctors actionable notifications that allow them to succeed in value-based care models, as we've shown in our actual results.

Moving to slide 16, you'll see that I've just highlighted a couple of the ways that this works. We've automated medical claims adjudication, for example, having processed over 4 million claims in just the last year. We've done a lot of work in terms of being intelligent about our utilization management. And we've also created a provider-facing platform that exists at the point of care that really incentivizes them with real-time actionable notifications about what they can do about the member that is right there in their office at that moment. And we found, as well many studies have found, that that's really the way to drive change and action in providers, by giving them that real-time feedback that they can use on the spot.

Moving into slide 18, given the history of success, given the technology platform that we've built, we think that there's a very clear growth strategy for us going forward. We're going to consolidate additional IPAs and enter new markets and geographies, proving out our model not only in California, not only in New York, but nationwide. We're going to build upon our next-gen ACO success, participate in future innovation models such as direct contracting, and we're going to continue investing in our technology platform to further drive clinical outcomes and lower total cost of care for our patients.

If you look at slide 19, there's an enormous serviceable addressable market – don't even talk about total addressable market -- for our provider services of this kind, and only growing as value-based care becomes more and more widespread nationwide. We estimate almost $1 trillion in 2021 for our serviceable addressable market in provider services, and we're just getting started.

If you go with me to slide 20, you'll see that we have a foothold at least in 9 of the top 25 counties by population in the United States, a lot of those obviously lie in California. A lot of those lie in New York state. But we're just getting started. We have a huge serviceable addressable market even in the markets that we already serve. And there's still a large swath of the country that we're looking to expand into that have not or perhaps are a little behind relative to California in terms of their adoption of value-based care.

Brandon Sim: Moving to slide 21, we're actively and very rapidly pursuing growth opportunities to capture a greater share of this large provider services opportunity. And like I mentioned earlier, we promise to get to around 2 million managed lives by the end of this year. There's a huge total addressable market here. There's no clear winner in the space. We've been doing this for a long time very successfully. And we think we are very poised, especially with the technology platform that we've built, to seize this and continue to expand upon the market leadership that we've demonstrated in the value-based care space.

Moving on to slide 22, I wanted to talk briefly about some of the IPAs that we've acquired recently. We acquired Alpha Care Medical Group and Accountable Health Care IPA, both in 2019. That's just an example of some of the strategic growth that we've been driving. We think that the benefits will show up within 2 to 3 years of close, as we continue to renegotiate contracts, some of which are long-term. And so that can take a little bit of time. And as we try to institute cultural change in terms of the shift towards value-based care and the onboarding onto the ApolloMed technology platform. And so we look forward for those investments to continue paying off and look forward to adding new investments to the ApolloMed family.

Moving on to slide 23, I also wanted to highlight our recent investment in New York City in the five boroughs in CAIPA MSO, which is a leading IPA in New York City, serving over 500,000 managed lives with over 1,000 providers. And so we will own 30% of CAIPA MSO after the close of this transaction, and we'll be providing them with not only value-based care advice but also onboarding them into the ApolloMed technology platform so that they too can onboard into value-based care and continue to serve their patients in the best way possible.

Moving to slide 24, I just want to summarize by saying that ApolloMed clearly has overwhelming advantages in the value-based care space, and management, myself, Eric, our co-CEOs and the rest of the team, fully intend on capitalizing 100% on those advantages. To summarize, we have a profitable and proven model with predictable and attractive unit economics, as well as further upside from risk-sharing arrangements that we take with payer partners. We have a scalable and repeatable growth playbook, and we believe that will drive us into hypergrowth in '21 and the years to come.

We have industry-leading technology driven by our years of accumulation of data that other companies simply can't match. We have a repeatable and strong flywheel effect that allows us to take our substantial lead and exponentially grow on top of that. And there's a large and rapidly-growing market opportunity there for us to take. We're just getting started on our story, and we're so excited for you to join us as we continue to spread

value-based care and help providers serve their patients in the best way possible nationwide.

Brandon Sim: Finally, with all those advantages, you might think that we would be a very expensive company. I want to kind of now go onto slide 25, and just kind of -- I won't make too much about this slide. But I wanted to kind of introduce to you, the investor community, some of the peers who are doing somewhat similar things in the public markets today. And a lot of these companies you'll notice are fairly recent entrants to the public markets. And I won't speak too much about this, but we believe that we have an extremely exciting story that is overlooked and is kind of really cutting edge in terms of where we sit in terms of our competitors and peers in this space.

So for slide 26, I will turn it over to Eric Chin, our Chief Financial Officer, to talk a little bit about our financial overview and expand upon future growth and how that might be financed, as well as go over how we're doing in recent years. Eric?

Eric Chin: Great. Thank you, Brandon. Appreciate that. So I'm moving into slide 27, the historical financial profile. Starting in the top left corner, from 2014 to 2017, the membership grew by a CAGR of 27%. And that was due to the acquisition of two IPAs here in the San Gabriel Valley of California.

From 2017 to 2020, our membership grew by a CAGR of 6%, primarily due to the 2019 acquisitions of Alpha Care IPA and Accountable IPA. As we move over to the right-hand side, you can see that our membership growth is driven by the growth in contracted physicians, which increased 75% from 2017. This is a trust industry, and patients do tend to follow their physicians.

In the bottom right-hand corner, you'll see that our total growth from revenue was an increase from 2019 to 2020, primarily driven by the following. There was a $20 million shared savings earned from the settlement of our 2019 ACO performance year. We also had the Alpha Care acquisition online for a full year, and that provided approximately an incremental $52 million of top line revenue. The Accountable acquisition was online for a full year as well, and that provided an additional $29 million of top line revenue.

Moving over to the bottom left, you'll see our strong performance for the 2020 year, which was driven by the following: $13 million of bottom-line impact from shared savings earned from the settlement of our 2019 ACO performance. Also included in that number was a $25 million decrease in our medical claims expense during 2020 as a result of decreased utilization from COVID-19.

Eric Chin: As I move along to slide 28, I'll take you through a quick summary of our selected financial results. From a revenue perspective, our capitation revenue was a 3% increase, driven by a $4.3 million increase from organic membership growth at both Allied Pacific and Alpha Care in the first quarter. Our risk pool settlements and incentives demonstrated a 60% increase due to a $6.8 million increase in risk pool settlements. And this was due to a decreased utilization at our hospital partners from COVID-19. This revenue was reported on a lag, so it does tie to the 2020 stoppage in hospitals for emergency-only usage. Our management income remained steady, but we continue to pursue additional MSO contracts here in Southern California, with our technology platform being an attractive way to win business. Lastly, there is fee-for-service, which is not a big piece of our business, but we do expect a post-COVID return to normalcy for our surgery centers and heart centers.

From a bottom line net income perspective, we benefited from a decrease of $2.4 million in the first quarter, and that was primarily due to the reduction of third-party consulting and professional costs as a result of efficiencies gained from our Company's technology platform.

Moving along to slide 29, our guidance for 2021, I will note that there are no acquisitions built into this guidance. From a revenue perspective, we expect steady increases and no major changes to the revenue mix. From an EBITDA and margin perspective, we do factor in a post-COVID-19 return to normalized margin in the second half of 2021. But this is also offset by improvements in our margin as a result of the technology platform.

Moving along to slide 30, from a revenue breakdown perspective, we talked about this earlier. But our capitation is over 80% of stable diversified long-term contracts with health plans. Our risk pool and incentives include our full risk arrangements with our hospital partners and the ACO shared savings that I talked about earlier. Our management fee revenue is typically low double-digit percentage of revenue from our third-party managed IPAs.

With that, I'll move over to slide 31, our balance sheet highlights. And so from a balance sheet perspective, we do have significant capital available to deploy towards the acquisitions and investments to get us to the 2 million managed lives. We have an availability of $25 million on our revolver currently, as well as a solid leverage profile. Our consolidated leverage ratio was 1.44 times at the end of the first quarter, as well as our consolidated interest coverage ratio was 18.2 times at the end of the first quarter.

Moving along to slide 32, our capitalization table, just in summary here, we calculate in a market cap of about $1.7 billion. Then we add in our bank debt of $243 million, less cash and cash equivalents of $141 million.

And that arrives at an implied enterprise value of approximately $1.8 billion.

In conclusion, our historical financial performance, coupled with our ability to raise guidance during the pandemic, continuously beat analyst expectations, and our strategies for nationwide growth contribute to a tremendous investment opportunity. We thank you for your time. And with that, I'll turn it back to Rob.

Robert DiGia: Thank you, Brandon. Thank you, Eric. I will now move to the Q&A portion of the presentation. As a reminder, if you'd like to anonymously submit a question, please type your question in the Q&A prompt on the presentation screen. I'll give it a few seconds to queue up.

All right. Our first question, Brandon, Eric, could you go a little deeper into describing the Apollo Medical model? You've got an IPA, an ACO. How much of the premium dollar is Apollo Medical actually responsible for? That being a leading question to the breadth of your technology platform and your ability to manage risk.

Brandon Sim: Hi, Rob. Thank you for giving us that question and thank you for having us here at this conference, at the UBS conference. Anyway, as a quick recap, we have under the ApolloMed family, ApolloMed Holdings Company, there is over 12 IPAs, some of which we own and some of which we manage. There is a managed service organization which provides, like I mentioned earlier, health care administrative services for the rest of our organization, as well as for external clients. And finally there is an ACO segment, next-gen ACO, where we take risk with CMS on Medicare fee-for-service patients.

Eric can talk a little bit about the revenue breakdown between those segments. But in terms of the amount of premium that we take in each of those segments, for the IPA side of things it really varies depending on our payer contract. But depending on what it is, we can take either professional, which will be around call it 40-ish percent of the premium, to professional and hospital facility risk, which would be closer to 80% or 85% of revenue. Basically all of the medical services costs we would potentially take risk on, again, depending on the contract.

On the ACO side of things, we actually are responsible for paying out all of the care for the patient. We're assigned a benchmark dollar amount. Like I mentioned earlier, in 2019, it was around $500 million for 30,000 patients -- for our aligned beneficiaries, rather. And depending on how much it actually costs to take care of those patients, we would receive a portion of the shared savings from CMS. So that's kind of how the dollar breaks down, so to speak. And Eric, maybe you can also chat a little bit about how the revenue breaks down for ApolloMed.

Eric Chin: Yeah, sure. Thanks, Brandon. Just to give some color for the revenue breakdown, our Medicare and Medicaid typically breaks down to approximately 40% each of the total revenue with commercial making up about 20%. Our capitation revenue where we're taking the full risk, was $557 million for 2020, and then the ACO shared savings that we recognized in 2020 was about $19 million.

Brandon Sim: Thanks, Eric.

Robert DiGia: Thank you. As a follow-up, there's a question from the participants regarding the distribution of the membership across commercial, Medicare and Medicaid, if you can share that with the audience.

Brandon Sim: Yeah. I'll let Eric take that question. I believe we haven't traditionally published the breakdowns in terms of line of business. But to the extent that Eric would like to share, happy to let him do so.

Eric Chin: Yeah. Roughly speaking, the breakdown is about, let's say, ¾ to Medicaid, and then about the remaining ¼ between Medicare and commercial from a member count perspective.

Robert DiGia: Thank you. Next question is related to the closing of the CAIPA MSO transaction. You indicated that would be later this quarter. Any guidance related to financial impact, and most importantly, how did you source this transaction?

Brandon Sim: Sure, yeah. In terms of the sourcing of it, it's a relationship that we've been working on and developing fairly organically really over the last five years. As we scale our model, our value-based care model across the United States, we're always in chats with physicians who are interested by the idea. Perhaps the idea of it piques their interest a little bit, but they're not sure exactly how they would exactly onboard onto a value-based care arrangement with payers. They're not sure how they can succeed, or if they even might be able to succeed in such an arrangement.

And so it's really a matter of one, proving it out in the markets where we already exist, two, developing and proving out over a long period of time how the technology platform would allow them to succeed in these arrangements financially. And three, proving out how it would lead to better clinical outcomes for their patients, which is something they obviously care very deeply about. And so over the course of almost five years, we've been speaking to them. We've been demonstrating our results here in California and in other markets that we serve as well through the ACO. We've been showing them the technology platform, and we've been onboarding them into the idea of engaging in value-based care arrangements with payer partners.

And this is really a culmination -- I don't even want to say the final

culmination, perhaps even just the first step of formalizing a relationship in which we're able to bring on over 500,000 members onto the ApolloMed platform. It represents really just one example in how we're going to take this model we've developed and perfected here in California and throughout the nation with our ACO and expand that to more and more populations in other markets that are ripe for disruption in terms of moving to value-based care.

In terms of the timing of the transaction and perhaps some of the financial impact, I'll leave it to Eric to chat about some of those metrics.

Eric Chin: Yeah, sure. Thanks, Brandon. So we're still targeting the timing to close by the end of second quarter here. And what we have publicly disclosed at this point is a 30% investment in CAIPA's MSO business. I can tell you that it will be accretive to our P&L. But at this point, we have not disclosed our overall financial impact publicly, out of respect to our partners in New York.

Robert DiGia: Thank you. Obviously the footprint of ApolloMed is broad. You have an IPA in California, in New York, and an ACO in nine states. Florida was identified as a potential area for expansion. Any initial thoughts related to the Florida expansion, IPA, ACO? How do you think about that opportunity in Florida?

Brandon Sim: Thanks for your question, Rob. Yeah, I mean I think we are always looking for markets in which there are physicians who are potentially on the border of moving to value-based care who don't feel quite equipped, like I mentioned, to do value-based care, and who have the desire to remain independent. I think one key aspect of the ApolloMed platform that I perhaps didn't get into as much as I should have is that it allows doctors to really remain independent, call the shots at their own practices. They don't have to work 9:00 to 5:00 and get paid a fixed salary by a large staff model, an Optum or Kaiser type organization. They get to call their own shots. They get to remain entrepreneurial. But they also get the upside of participating in value-based care arrangements through the ApolloMed platform.

I think I would kind of liken it to the shift from taxi drivers who work for a taxi company to being independent drivers with the flexibility and the upside of operating on an Uber-like platform, for example. And so in terms of answering your question about our expansion into Florida, absolutely, it's something we've had discussions about, without going into too much detail. I think it's a market where obviously Florida is very competitive, especially in South Florida. And so we're going to be prudent about how we expand. Florida may or may not happen due to the competitiveness there, due to the presence of other large competitors there, and very low rates and reimbursement schemes because of the competitiveness of Florida. So I think if I could lead you perhaps a little bit,

I think we would be focused on probably other parts of the country not named Florida, although we definitely would consider it as a potential expansion area for us, if that makes sense.

Robert DiGia: Yes, it does. And I think what you alluded to, Brandon, is part of the success in terms of your relationship with physicians is the technology platform. If you could just share with the audience for the last question, the capabilities of the technology stack that entices physicians to want to work with ApolloMed, and obviously drives the impressive financial results.

Brandon Sim: Sure, absolutely. So I think there are two main components to it. One is a back-end system that allows for the automation and really a removal, taking away the burden of doing really annoying day-to-day operational administrative things from the doctors. And doctors really appreciate that. So for example, things like billing, things like claims adjudication, processing claims, submitting claims, coding properly; all those things we take from the doctors and we do on their behalf, so that they don't have to spend their valuable time doing that. They could spend their time taking care of patients, which is what they're the best at, and really what they should be equipped to do.

So we've developed a workflow automation tool, as well as various internal tools, to allow for taking that burden off of physicians' hands. The other aspect of it is kind of the point-of-care tool that I mentioned earlier. So it's a tool that allows doctors to aggregate and look across all of their insurance partners. You've probably been to a doctor's office and you ask them, hey, do you carry my insurance or not. I have United or Molina or Aetna, or whatever it is. And they'll have to call the insurance company or log onto the insurance company's website and check. Are you an eligible member or what services and benefits are you eligible for?

Instead of having to do that for 20 different insurance companies they might be contracted with, they can all do that through one platform, which is the ApolloMed platform. They can check eligibility. They can submit claims not to 20 different insurance companies that they might be contracted with, but directly to ApolloMed. And when they get paid, instead of getting 20 checks every month and having to reconcile everything, they get one check from ApolloMed, again, as a pseudo single payer. So in terms of logistics, the one platform and the pseudo single payer aggregation really gives a lot of benefits to doctors. And I go again back to the Uber example, where instead of collecting a check or a Venmo or cash from every single individual passenger, they're just getting payments directly from the Uber platform, for example.

And then the other piece of it is the point-of-care tool allows for us to aggregate and use in an acceptable and anonymized fashion, of course, all the data that we've gathered about our population and about how we've taken care of that population profitably over time to really give the

doctor actionable insights at the point of care. And so again, I think I alluded to it earlier during the presentation. But it's a really big deal to give doctors the ability to see what they need to do, so that they don't have to memorize, okay, if I have a patient who is 45 years old and is a woman and hasn't had a mammogram in the last few years. I need to play this game where I need to remember that I should get them in scheduled for a mammogram.

The ApolloMed platform gets rid of all that. When the patient comes in, the order is already there for them. They're reminded of it in a little pop-up window. As they check the member in, as they're doing all the eligibility checks and benefit checks and all those things, all that will be integrated seamlessly into the provider workflow and allow them to really knock it out of the park in terms of these preventive measures which will both increase our value-based care incentives, as well as lower the total cost of care for that patient over time. And so those are really the key elements of the ApolloMed platform and how we enable and empower physicians to succeed in these value-based care arrangements.

Thank you, Rob.

Robert DiGia: Thank you. We're at the 45-minute mark. Thank you, Brandon. Thank you, Eric. I'd like to thank ApolloMed for presenting today and thank the audience for attending the 2021 virtual UBS Global Healthcare Conference. Thank you and have a good day.