Barclays Global Healthcare Conference
Apollo Medical Holdings, Inc.'s Company Fireside Chat
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Speakers:

- Steve Valiquette, Managing Director, Healthcare Payers / Providers / Technology Analyst
- Brandon Sim, Co-Chief Executive Officer, ApolloMed

Steve Valiquette: Okay, great. We're hitting the home stretch here in the middle of the afternoon session here on Day 1 of the Barclays Healthcare Conference. I'm Steve Valiquette, the healthcare services analyst. For our next session here we have Apollo Medical, and with us to my right we have Brandon Sim, one of the company's co-CEOs. This will be a fireside chat, so I think with that, I guess we'll dive right in.

Brandon Sim: Awesome. Thanks so much, Steve, and obviously, thanks to Barclays for having us here.

Steve Valiquette: Yup. So I think in this case, we'll go a little more high level. I think that all the investors know a ton about the company, but I think the biggest thing is let's just start with having you walk through the growth outlook for 2023 and one of the key growth drivers you see, especially breaking it down maybe organic versus inorganic, and then we can go from there.

Brandon Sim: Absolutely, yes. The company's gone through, I think for the new investors in here, the company's gone through a lot of change over the last 4 years. The company's been around for over 25 years, for most of its life as a private company. We went public via a reverse merger in 2017--a unique choice, to say the least. And since then, in 2017 and 2018 we didn't even do earnings calls, for example.

So really, the amount of change that has happened from 2019 until now in terms of professionalizing the company, building the right management team, building a technology platform purpose-built for value-based enablement, especially in the very mature value-based environment of California, where we were started and founded and continue to be headquartered, has been a long journey in order to unlock a lot of the latent value that has been in our populations in California and take that scalable model outside of California as well.

So a lot of the growth that we're seeing from 2019, from '19 to the midpoint of '23 estimates: 27% revenue CAGR, 28% adjusted EBITDA CAGR. It's very strong growth while maintaining the profitability that we've always had, with around $90 million of free cash flow being generated last year out of $140 million of adjusted EBITDA. So it's a real model that we have worked really hard over the last 4 years to codify, to build a platform around, and to take that into new regions in California, central California, the San Francisco Bay Area, as well as into new states like Nevada, Texas, and New York.

Brandon Sim: Breaking down some of the growth outlook for next year, we've guided towards a fairly large range on the revenue side, primarily due to a couple of factors. Organically, everything in the guidance is organic, so organically, we're looking at low to mid-teens pure membership headcount growth, with the balance of the growth made up by improved payer mix and by some very incremental growth in our new regions in Texas and Nevada. I say that it's incremental because all of those are primarily still fee-for-service markets that we are working to move towards outpatient or one day global risk, and we expect that to happen in the next 12 to 18 months. And so to this date, they are going to be very minimally contributing to revenue growth. But over time, that is something that's going to be a meaningful driver.

That being said, even in our core California regions in terms of membership growth and improvement in payer mix and blended PMPM, that's going to already drive, I believe, 17.5% revenue growth at the midpoint. It's actually going to be a little bit higher than that. We've also baked in some of the Medicaid redeterminations into that growth number. We expect around 5% to 15% of our Medicaid book of business to undergo attrition, and Medicaid represents around 25% of our revenue, so at the midpoint, 10% of that business on a gross perspective to be redetermined, maybe not qualified for Medicaid anymore. Ten percent of 25% is 2.5%. We expect that impact to be spread across probably 2 years, '23 and '24. So not a huge headwind to revenue growth, but still something. And we expect actually around 40% to 50% of those members to be recovered or recaptured into a different line of business.

As you all may know, we are line-of-business agnostic. We serve Medicaid members, commercial, exchange, Medicare Advantage, Medicare fee-for-service in our ACO. And so part of the benefit of that is that we can maintain care coordination as well as maintaining a risk-bearing ecosystem, even across different life circumstances. During COVID, for example, a lot of folks, unfortunately, lost their jobs. We saw them move from commercial coverage in the ApolloMed risk-bearing ecosystem to Medicaid or to a subsidized exchange plan, for example. It will be similar here with Medicaid redetermination. If folks-- we do expect 40% of those folks to come back in another line of business for us. And so that bridges us from the $1.1 billion or so of revenue that we reported in '22 to what's our baseline assumption for where we're going to land in '23.

Another big factor that we haven't taken into account in terms of that guidance is the acquisition of the Restricted Knox-Keene license that we announced late last year. For those who are unfamiliar, in California without a Restricted Knox-Keene license, a provider group is actually not allowed to take on risk in both professional, which is outpatient, as well as inpatient or hospital-related risks. We're only allowed to do patient risk, or Part B risk, in Medicare lingo. And so what that means is we're actually only taking risk on 35% to 40% of the premium dollar instead of 85%, even though we're doing the work in terms of having the hospitals' inpatient care managers, the transition of care coordinators, so on and so forth. And so pending regulatory approval, that's something that will also serve as a catalyst. That isn't even included in this guidance forecast for next year in terms of revenue growth, moving from 35% of the premium dollar to 85% on our 1.3 million value-based care members in California. Hopefully, that helps.

Steve Valiquette: Yes, definitely touched on a lot of subjects that we'll dive into a little bit deeper. One thing that's come up a little bit is within a lot of these publicly traded

companies that are focused on value-based care, there can definitely be a wide array of arrangements with the decisions as far as contractual relationships, how many are directly employed versus just contractually affiliated. I think you guys, we've built out a pretty detailed Barclays value-based care market model, and I think you guys stick out as a company with a fairly large number of primary care physicians that are affiliated, but I think a smaller number that as far as the physicians are directly employed versus just affiliated.

Brandon Sim: Correct.

Steve Valiquette: Maybe just talk to the strategy of when it's right to directly employ a physician versus you just having that contractually affiliated relationship, and what are the pros and cons on both sides of that?

Brandon Sim: Yes, absolutely. So by way of background, it's around 11,000 affiliated physicians in the network. The contract is on either our paper or one of our medical groups' paper. But in comparison, or in contrast, like you said, only around 30 owned-and-operated primary and multi-specialty clinics. So as you said, definitely a larger emphasis to date on the affiliate model and enabling existing physician groups and physician practices to participate in and succeed at value-based care.

That's been by design. It's asset-light. These are things I'm sure folks have said before. But it's a quicker way to enable value-based care in a place where that might not have been the case before. CMS, for example, has stated that they want all original Medicare patients in an accountable care arrangement by the end of the decade, 2030. It seems infeasible to me, if that is the true goal, to build enough or to acquire enough or to employ enough physicians under one entity or a group of entities, even, to accomplish that goal as quickly as CMS might want it to happen.

Working with the existing infrastructure, working within the bounds of the trust that physicians in the community have built with patients over sometimes decades of their lives, following them from job to job, following them into Medicare eligibility is something that we strongly believe in. And enabling those doctors who are already ingrained in the community, who understand the specific levers that it takes to change patient behavior, and then giving them the tools to participate and succeed in value-based care, we think, is sometimes more effective than going in, employing a doctor, and expecting that they can build these relationships with patients from the ground up within a very short period of time in terms of expecting ROI on that investment. So I think that's a big part of why we like to partner with physicians, especially those who have already been ingrained in the community, because sometimes they don't have the ability or the knowledge or the time, frankly, to engage successfully in value-based care. And that's where we think we excel at doing that.

The reason that we also have clinics as part of the model is because it's important to supplement supply of healthcare when there is excess demand for that care in a particular region. So what we find is if we're able to partner with physicians who are deeply ingrained in that community and can serve those patient populations, that's wonderful; let's do that. If there's too much demand, for example, and not enough physicians there to fill demand, we might have to build new centers, and we have done that. We've built new centers. We might have to acquire practices and make them more efficient, something we've done as well.

Brandon Sim: And so at the end of the day, the operating model, technology platform, is agnostic to whether we own the clinic or not. It really doesn't care. It's not like there's a different clinical pathway if we own the clinic versus it's a physician that we don't, that's an entrepreneur and has a private practice. The recommendations are the same; the operating models are the same. The economics are a little different, obviously, but at the end of the day, we're going to do what is necessary to deliver a coordinated, high-quality experience to the patients.

Steve Valiquette: Okay. Also, you remind us to just, within the 11,000 total physicians, mostly affiliated, what's the current mix related to PCPs versus specialists? And is that ratio a very different number within 30 clinics that are directly owned by you guys? And also, how has that ratio of PCP versus specialist evolved over time and going forward, for that matter?

Brandon Sim: Yes, it's a good question. Technically, we haven't disclosed that ratio, but I would say it's around 20% to 30% are PCPs, so call it a couple thousand, 3,000 PCPs out of that 11,000. The rest are specialists. Again, all contracted in our paper. It's not piggybacked off of insurance contracts or anything like that.

Of course, that ratio is definitely different when we look at our employed model clinics. Our employed model is primarily primary care physicians. It's over 50%. We do have some specialties. We own a CLIA-certified lab as well. Really, it's all about--it's not that we want to be a major lab player. It's about fulfilling demand for these kinds of services in places where historically they just haven't existed. So absolutely, the mix looks different in our employed model because we've focused specifically more on primary care.

Steve Valiquette: Okay. Just to build on that a little bit further, so then within the employee model, then, as far as the specialties that you're focused on, do you just want to give a little more color around which areas in particular that you're really trying to drive value-based care initiatives?

Brandon Sim: Yes. It's still primary care, as we said. We own--it's a lot of high-demand specialists who traditionally may not want to work, or by whatever circumstance, just are not in a particular region where we have a great density of patients that when we feel the need to augment that demand and supply imbalance. So for example, dermatologists don't--we're in LA, but typically dermatologists don't tend to go too far east, for example, downtown or Beverly Hills. It's a stereotype to say that, but it is more difficult in terms of access in the more rural regions or more low-income regions to high-quality dermatologists. And so, for example, we do employ several dermatologists for that reason, to fulfill demand for medically appropriate dermatology services in certain regions that traditionally wouldn't have someone in that community to serve them.

Cardiology's another example where it's very difficult. OB-GYN is another example where often culturally sensitive OB-GYNs are hard to come by in certain regions, and not everyone has access to the same level of care as they might living in a more densely populated region. So that's also--these are just some of the specialties that we employ. But primarily it's primary care physicians.

Steve Valiquette: Okay, got it. Okay, so in that first question when you provided some of the color on the business, you talked about some of the states already where you're looking

to expand outside of California. So you don't have to re-rattle those off, but I think, just given how competitive value-based care has become and will be across the entire healthcare continuum, across almost all geographies, it's probably more challenging than ever to recruit physicians in some of these new markets. What's the strategy when you are entering these new markets? Are you still trying to do it more through the affiliation, or do you want to have the anchor locked in, employed physicians just to give you more control over cost containment and everything else when you're thinking about entering the new markets?

Brandon Sim: Yes, totally. That's a good question and one we've thought about a lot because in some sense, Steve, it really does feel extremely competitive. All the companies here at this great conference, a lot of folks are really talking about investing billions of dollars in value-based care, not only in primary care, but now we're hearing specialties as well. And then that's a great area of investment for a lot of folks.

But on the ground it's interesting, because it often feels still that there's an amazing amount of white space, millions of completely unmanaged fee-for-service construct members that really, it's not like we're fighting with some of our peers to get. They're just out there, and it's our ability to go and implement our clinical model repeatably and operating model as well repeatably in some of these areas that will allow us to win or penetrate some of these markets.

So in some sense, yes, it feels like it's very invested in, but if you look at the broad landscape, I truly do feel like there's--the numbers bear it out as well--the percentage of patients in an ACO, for example is nowhere near even 50%, definitely not 100%. So there's still a lot of white space out there, I think. The key is going to be who is able to scale the model effectively, who is able to provide a value prop to providers that gets them paid more and allows them to spend more time with their patients and bringing that model to those places. And it's something I think we're very focused on.

Of course, it's also about depth over breadth. We'd rather have a real very coordinated system that we've created in--just to rehash names really quick, Nevada, Texas, New York--versus having a more shallow presence in 30 states, for example, because I think that's where we can really start to affect clinical outcomes in a meaningful way.

Steve Valiquette: Okay, got it. Okay. Even though the company's been around for a long time on a relative basis, pretty strong market share and presence in the state of California and just the overall model, I think only more recently over the past couple of years have you really started to highlight the internal technology, label yourselves as a tech-enabled VBC provider. And for a little while there, that was worth probably 3 times the market cap versus what the company was getting previously. But maybe just talk about the technology component of what you're trying to do. I think from meeting with you guys previously, I think a lot of that, almost all of it, was developed in-house. But just talk about how that could be a point of differentiation on controlling costs versus some of the other companies that are out there.

Brandon Sim: Absolutely. Yes, I'm a technologist by background. I'm not a clinician, I have to admit. I did my undergrad and graduate studies in computer science and building machine learning models. I used to do that at Citadel on the buy side as well. A lot

of my background is in risk management, alpha generation, and machine learning. And I'm probably the first to admit that tech enablement is not the end-all and be-all in healthcare, and it will not be, at least in the foreseeable future.

Brandon Sim: We do build, like you said, all of our technology in-house. It's a recent thing because I was the first software engineer ever employed by Apollo, and we now have a team of close to 50 engineers, data scientists, machine learning experts in-house, onshore. But all of that has been for the aim of enabling physicians and not just to say that we have a shiny technology platform. And the results bear that out, I think. From 2019 until, I mentioned earlier, until 2023, we've really driven scalability, we've driven revenue growth, and we've driven real earnings by being efficient on the G&A side as well as by helping physicians with maybe optimizing some of their care workflows.

And so I don't want to go too much into it given time, but the technology platform is really multifaceted. We built what the business has needed and not what we think philosophically AI this or machine learning that, even though that is what my background is. For example, we built payer tools. We automate 90% of our claims processing. That's really saved costs in terms of--there have been estimates out there from payers, hospital systems, $10 a claim. We process millions of claims a year, many millions of claims a year. So automating a lot of that has really cut down on costs.

We automate 60% or more of our prior authorization requests. I might even add that we are delegated for all of these payer-related services in California. I think that's rare, unique to the state of California. Outside, the payer retains control of prior auth claims payment, credentialing, contracting, and so forth. That's all something that we do in California for the same percentage of premium. And so for prior auth, for example, it used to be that even the most routine, obviously medically necessary requests needed to be reviewed by a nurse or a coordinator. Now the obvious ones are automatically approved. The patient can actually, in that same visit, get that approval and then go do that procedure, the follow-up procedure, right away. This is a big deal.

One example I'll give in dermatology, again, oftentimes for a biopsy, for example, the patient will need to go get an initial consult with a dermatologist, get a referral for the biopsy, get it approved, and then go back to the dermatology office to actually get the biopsy performed. It's an extra visit for absolutely no reason. What we can do, if we can automatically approve that authorization, as we approve the auth in that same visit, the patient doesn't have to come back. They bill once for the visit and the biopsy altogether. The patient saves a lot of time as well and gets their results back faster. Higher patient satisfaction, the derm doesn't feel like they've wasted time having to see the patient twice for no reason. It's simple things like that where we can really enable workflows, at least on the payer-related side.

And obviously on the provider-facing side, we've built--we have an NCQA-certified HEDIS engine to calculate gaps in care. We have HCC suspecting algorithms. We've built models to predict different risk profiles of patients and stratify patients by risk. And all that flows into clinically guided care pathways for each of those risk stratification buckets that our team of clinical coordinators and NPs and social workers at the corporate level--we have hundreds of them--use that platform every day in order to identify and then act on parts of the

population that are higher risk. All that together--it's a couple of basis points here, 50 basis points there--all of it leads to these industry-leading clinical outcomes in terms of inpatient bed days, in terms of avoidable readmissions, in terms of ER utilization and so on and so forth that drive the profitability of the business.

Steve Valiquette: Okay, all right. Just jumping around here a little bit, this next question not as close to this as I would be, because I don't officially cover the company right now. But just given that 80% of your revenues in '22 were derived from capitation payments, how much disclosure have you given around just your mix of the individual payers and where your strongest relationships are and where most of the revenue is coming from, unless you're not giving any color on that. But just wanted to just peel the onion back on that a little bit.

Brandon Sim: No, totally. We have--I don't think we call each payer out by name, but we do have a pie chart in our investor deck and 10-K around the distribution of payer revenues. The biggest guy is 50-ish percent of revenue. I think it's no surprise that that is CMS in terms of Medicare payments. But other than CMS, there's not a single payer, I believe, that has more than 20% of our revenue.

In a way, we've played Switzerland with a lot of our payer partners. We want to have a payer-agnostic relationship with the patients. That has served us well, for example, in times where, especially the payer space in MA has been very competitive in terms of benefit design and rebates and so on and so forth. And so, for example, in southern California--this is local market dynamics--but we saw Payer A, not to be named, lose a lot of membership to Payer B, who had very strong supplementary benefits that year. But at the end of the day, we got a lot of questions about, "Hey, does this affect you? Payer A's stock price was affected materially by this." At the end of the day, it didn't really matter because we had contracts with both. We're payer agnostic. We continued the continuity of care for that patient regardless of the benefit package they were choosing relative to the formulary that broker relationship that they had that particular year in AEP. We were able to continue to deliver them care--same PCP, maintain that relationship, and actually in subsequent years, some of those benefits were peeled back so the patient moved back to the original plan--all good. Same continuity of care.

It's really that longevity of that patient-provider relationship that we can engender in this payer-agnostic model that yields some of the outcomes of value-based care. Value-based care is not a game for 1, 2, 3 years. It's an investment you make now in a patient's health that may not materialize in improved MLR, improved clinical outcomes for many years to come. And if you're investing now and that patient is no longer in your risk ecosystem a few years later, it's almost as if those investments you've made, those benefits are going to accrue to someone else, the new risk-bearing ecosystem that they're in, even though you might have been the one to make those investments into their health--preventive care and all that--in the first place.

So I think the key part is not only providing the preventive care that we're talking about that technology enables, but also keeping that member in your system so that when the benefits accrue, they accrue to you and not to someone else. And so a big part of our payer agnosticity is to keep that member in our risk-bearing ecosystem so that that actually happens.

Steve Valiquette: Okay. And within that 50% mix--that is, CMS is your largest payer--I think you've got a pretty good mix of Medicaid within that, where it's not just Medicare. But maybe--we're running low on time here--but maybe just talk about, remind everybody what you expect around Medicaid redeterminations and how that impacts your overall business. Is there a way to neutralize that, and how are you guys thinking about the exposure on that and how that impacts the flow of the mix of profitability as the year goes on, and also into '24 as well?

Brandon Sim: Sure thing, yes. That and the RADV stuff has been, I think, the top two questions we've gotten. It totally makes sense. I think I mentioned earlier, Medicaid, 25% of revenues. We expect 10% to 15% of the members to be probably not eligible post redetermination. That impact will be spread over '23 and '24, call it 10% at the midpoint spread over 2 years, maybe 5% of that 25% of revenue each year. We expect to recapture 40% to 50% in exchange or commercial products, probably a subsidized exchange product, potentially. And we have all lines of business, so we would probably recapture that. So the overall impact probably wouldn't be the worst in the world, given where we stand today. We'll obviously update the group of investors if that changes.

There are also tailwinds in terms of California Medicaid. As of 1/1/23, all people who qualify from a financial standpoint, regardless of immigration status in California, signed by Governor Gavin Newsom, are going to be eligible for Medicaid. That changes everyone above 26 years old on 1/1/24. So there are slight tailwinds to Medicaid eligibility, obviously bound by puts and takes with Medicaid redetermination.

In terms of '24 RADV--I know we're out of time--but I think that's just a common question I've gotten. We are actually typically under-coded. This is public information, but our Medicare book of business is running at 0.95 to 1 RAF score across the board. Like I mentioned, this has not been a super technology-enabled company prior to very recent times, and it takes 18 months for some of the RAF sweeps to come in, and so some of the more recent efforts we've built around getting coding more accurate haven't really showed up yet, and we're still under-coded.

So I think--I know everyone says they're going to be fine--but we've run the analysis on the prevalence of some of the big hitters that are going away--diabetes with complications, morbid obesity, some of the CHF items--and it's really not going to be a big impact. That, coupled with the higher demographic from new members' RAF score, we think the puts and takes are going to come out, on balance, around equal, or if not, even a slight tailwind. So truly, we've done some analysis and are not too concerned about RADV either. We'll see what happens on April 3.

Steve Valiquette: Okay, great. Yes, that's right. All right, that's certainly helpful. Okay. But with that, we went over by a few minutes, so I want to thank Brandon for his time today and for the rest of the conference. Thanks.

Brandon Sim: Absolutely. Thanks, everyone. Thanks, Steve. Really appreciate it.