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

- Ethan Taylor, Associate, Healthcare Investment Banking Group
- Brandon Sim, Co-Chief Executive Officer, ApolloMed
- Chan Basho, Chief Strategy Officer, Interim Chief Financial Officer, ApolloMed

Ethan Taylor: Good afternoon, everyone, and welcome to the Apollo Medical company presentation. My name is Ethan Taylor. I'm an associate in J.P. Morgan's Healthcare Investment Banking Group. It is my pleasure to introduce Brandon Sim, co-CEO of Apollo Medical. As a quick note, at the end of the presentation, there will be some time for audience Q&A, so please have some questions ready. With that, Brandon, I'll let you take over.

Brandon Sim: Awesome. Thanks so much for the kind introduction. Also joined here on stage by ApolloMed's Chief Strategy Officer and Interim CFO, Chan Basho, and we'll both be taking questions after the presentation. Just want to start off by thanking everyone for being here, braving the rain. Thank you to the J.P. Morgan team for having us here. And the obligatory regulatory slide.

ApolloMed is a physician-centric, technology-powered healthcare platform that is accelerating the future towards one in which everyone can have access to high-quality, value-based, evidence-driven healthcare. To that end, we are serving entire communities of patients, not just focusing on any one given segment, such as Medicare Advantage, Medicaid, or commercial, or ACA exchange, but really building flexible and interoperable technology that allows us to serve members throughout the continuum of their stage of life, the type of plan they choose, the type of payer they choose, whether they have a job or not, or what ethnicity or age they might be.

Because of that focus on the entire community, we're able to access a large TAM of two trillion dollars and growing across all populations and regions.

In addition, the scalable approach that we've developed means that we can allow entrepreneurial providers, both those who own their independent practices or those who want to be entrepreneurial and work with us in one of our owned clinics, to deliver value-based care and effectuate industry leading clinical outcomes, which we'll talk a little bit about later.

There's also a proprietary technology platform that we've built over the last four or five years, which allows us to leverage the 25 to 30 years of real world data that we've had taking risk in the California market, systematizing the things that need to be systematized so that we can scale in a sublinear fashion, and replicate this very successful California clinical model we've created, not only in new geographies in California, but in states and geographies outside of California as well.

Brandon Sim: All this means that we have profitability, we have highly replicable unit economics, we have stable revenue growth year over year to the tune of around 25 to 26 percent over the last three years, and adjusted EBITDA growth of around 36 to 45 percent, depending on the range for this year's guidance.

At the heart of what we believe in is the sanctity of the patient-provider/PCP relationship, and all that we have built is to enable that relationship to flourish and for the provider to help change behavior in the patient over the long term.

We believe that value-based care is, at its core, must be done: one, at scale, and two, with low churn, because investments that we make in a population's health today must be realized over the lifetime value of the patient in our risk-bearing ecosystem. That's what we've designed our payer-agnostic and model-flexible platform to support.

To that end, we have longstanding relationships with over 20 payers, national ones, local ones, familiar names, and unfamiliar names alike, that we've had and cultivated for over 15 years. We currently serve four states directly via our independent practice associations, or IPAs, our medical groups, and our ACO, and another 16 states outside of that via our affiliate ACO network.

All that has led to over 40 percent growth at the midpoint for 2022 relative to '21, and a 25 to 26 percent CAGR over the last three years. We're well diversified across various lines of business, like I mentioned, around 55 percent in Medicare, 25 percent in Medicaid, and the balance in commercial and other third parties.

And a majority of our revenue is extremely predictable, recurring revenue in the form of capitated payments from our payer partners.

Like I mentioned earlier, that focus on the entire community, allowing our providers to serve an entire family when they come in, not just the senior, not just the one with a job, not just those who qualify for Medicaid, really allows us to capture an outsized TAM, and is better for patients, providers, and payers in the ecosystem.

Patients, for example, do not have to leave the ApolloMed ecosystem if they change their walk of life. For example, during the COVID pandemic, which is still ongoing, but during the worst of it, many patients lost their jobs, for example. They had to switch from commercial insurance to Medicaid or find a plan on the exchange.

Even through those changes in their life circumstances, they were still in our ApolloMed risk ecosystem, and we were still able to support them with the same technology, infrastructure, and care teams, the same way that they did when they had a different ID card in their wallets. If they age in, for example, to Medicare eligibility, we can also support them in the same way. So it means that we can really longitudinally effect outcomes in a patient population over time and reap the benefits, financially, of the investments that we make in their health at one point in time, at a later point in time.

In addition, it's better for providers as well. There have been countless providers who have told us how challenging it is, how frustrating it is to have to switch

between various point-of-care solutions depending on what patient walks in the door that day. If it's a commercial patient, I've got to log into this website with my commercial insurer. If it's a Medicare patient, I've got to use this other risk-bearing entity's proprietary platform for those patients. What the focus on the entire community allows us to do is provide a unified and full-stack solution for providers without having to switch between various point solutions.

Brandon Sim: Finally, for payers, it's just much easier to work with us as a risk-bearing partner. When they're trying to reinsure some of the risk on their patients, we are able to take both Medicaid, commercial, exchange, Medicare off their hands instead of focusing only on one patient segment, forcing them to find another risk-bearing entity to take on their remainder of the risk.

We think this model, focusing on the patient-provider sacred relationship, focusing on the community, enabling providers to serve that community well is going to be the bedrock of our consistent growth and profitability for decades to come.

Taking a step back, as I was alluding to earlier, it really is challenging for providers in a world transitioning towards value-based care. As many of you know, the promise of value-based care has been talked about for decades, but we are still, we think, in the infancy of its adoption throughout America.

Part of the reason adoption is slow is because providers face such complex administrative care coordination and operational hurdles to even participate in value-based care, even if they might want to, set aside not even talking about the providers who may or may not actually want to participate in such a model.

What ApolloMed does is we act as a pseudo single payer, connecting the health ecosystem for payers, providers, and patients alike, and integrating clinical technology and administrative support for our providers on the platform. Following me through the diagram here.

First, the over 20 payers that I talked about earlier will pay us a percentage of their premium dollar in order to assume risk in a value-based contract for their patients, again, across multiple lines of business if necessary.

Then for all of the providers on our platform in the ApolloMed ecosystem in the middle of the slide, we are actually acting as a single payer for them. All of their checks are coming from ApolloMed or one of our affiliated entities and not necessarily 20 different checks from United, Cigna, and Humana, Centene, or CMS.

Finally, we reimburse providers in a subscription model and share savings with them, thus aligning their financial incentives with ours and with the patients.

Diving a little deeper into what that ApolloMed ecosystem looks like, at the center of this ecosystem of course is that PCP-patient relationship that I was talking about earlier.

What we do systematically in each geography and community that we serve is we take that PCP-patient relationship and build a high-quality specialist and facility

network around that PCP and their patients. Then we onboard them onto our technology platform, giving them administrative support in terms of revenue cycle, in terms of contracting, automating their operations, which allows them to have point-of-care tools, which we'll go a little bit deeper into later, as well as analytics and risk stratification.

Brandon Sim: Finally, we support them clinically via care teams that we employ at the ApolloMed level, over 350 healthcare professionals who serve as care teams, on care teams who serve in quality programs or clinical support programs, who perform utilization management and care management or do social work to support the patients in our ecosystem and prevent them from falling through the gaps in care in between their provider visits.

At the end of the day, what this means is that our patients are supported longitudinally, even if they make separate visits to fragmented parts of the care ecosystem. It means that physicians have choice, whether they want to be employed, whether they want to be entrepreneurial, or whether they want to continue practicing the same way they've been practicing for decades.

It means that providers don't have to worry about the administrative reporting technology problems of the status quo situation. And it means that patients can see their same PCP and the same specialist network, regardless of their walk of life, life circumstance or age.

Here is just a couple of examples of some of the technology that we provide to our providers and to our patients. This is a screenshot of the ApolloMed provider portal. On the right side, you'll see some proprietary information is blurred out. But you'll see that providers have access to viewing their quality measures, which we're certified by National Committee for Quality Assurance, NCQA, to calculate. It shows them their risk adjustment. It shows the member eligibility. It allows them to track care plans across a patient's various visits to independent doctors in an ecosystem. They can submit claims, prior auth requests. They can calculate those gaps in care. They can finally see a longitudinal patient record that incorporates not only their EHR information, but also the EHR information from a specialist visit or from a lab or from a radiology center, for example.

I'm sure many of us have had the experience of having to fax or call a specialist to get them to transfer the record to another provider or download something onto a CD-ROM and bring it to the next person.

The longitudinal patient record is what allows us to get around some of those problems that currently exist.

In addition, we also build technology for patients. This is a patient app that we have that allows for patients to see and message our virtual nurse practitioner clinic, for example. We hire NPs in our care teams who are tasked to respond to patient requests, patient questions. Patients can request a telehealth visit, for example, and enter a virtual waiting room. They can check their personal data, not only from the EHR, but also through remote patient monitoring programs that we have built. You can see there's an RPM tab on there. Finally, they can see their past and upcoming visits as well. This is constantly in production. It's constantly being improved as patients request it.

Brandon Sim: These are only the patient- and provider-facing applications. On the back end, we've also got payer tools where we automate, for example, over 90 percent of our claims that are processed. We process close to 10 million claims a year. The only way to scale sublinearly as we move into new geographies is to have this kind of automation that allows us to do this at a low OpEx burn. We also automate a lot of our prior authorizations.

Simple tasks that don't need a lot of complex medical knowledge to know that something should be approved should just be automated. What that means to the patient is that they can have access to care a lot more quickly than they might otherwise waiting for an insurance company 24, 48, 72 hours to approve their authorization.

At the end of the day, all of this means that we built what we think is a flywheel that is powered by 30 years of experience in the California managed care market. It means that we can attract providers differentially into our network, especially the high-quality providers, and with them, attract patients to be long-term participants in the ApolloMed health care delivery ecosystem. That will allow us to continue to invest further dollars in that ecosystem, driving down medical costs for those populations over time, and reaping rewards financially to the tune of 10 to 20 percent long-term adjusted EBITDA margins.

There are a lot of logistics in terms of how we actually grow, but at the end of the day, they all fall into two very simple categories. We either increase the number of members that are in the ApolloMed risk ecosystem, or we take additional risk on the members that are already in that ecosystem. What we've done is highlighted a very clear strategy to do both at the same time, which will allow us to drive 30 percent growth year over year in the medium term.

In terms of expanding membership, many of you may know that we started off in California. In our core California counties, we can leverage our dense, high-quality provider networks to continue differentially attracting patients who want to be seen by our doctors, who want to use the patient app, who want to be able to schedule visits seamlessly, who want to have access to specialists, especially high-demand specialists, at a reasonable amount of time. They will join our network and become part of the ApolloMed health ecosystem in these core counties.

In new California counties, such as San Francisco, where we are today, we are continuing to expand our primary care presence, extend our specialist and facility partners around the primary care patient relationship, like I described earlier, and continue to grow in terms of partnering with new provider groups in new counties.

Finally, outside of California, we've recently entered three other states, Nevada, Texas, and New York, with a very similar model, starting off with primary care, building high-quality specialists and facility networks around primary care, and supporting everyone with the infrastructure, both in the operational, administrative, and technology parts of the business.

In terms of increasing risk in value-based contracts, there are some interesting things that we can do as we “flip” patients from a fee-for-service construct to a value-based construct. Historically, outside of California, patients are normally

paid, or providers are normally paid when patients see them on a fee-for-service basis in a volume X dollars per visit construct.

Brandon Sim: What we are able to do in California is not only align patient and provider incentives with ours, but also do that by having capitated payments flow through to us as the single payer downstream to our provider network.

Our ability to have done that in core California markets is something that we'll try to replicate in Nevada, Texas, and in New York, and we think there's a huge opportunity to grow revenue by doing that.

Currently in California, we serve only professional risk. What that means n our GAAP accounting is that we are taking around 40 percent of the premium dollar, give or take, in our GAAP revenue.

We recently acquired a license called the Restricted Knox-Keene license, which allows us to, pending regulatory approval of course, take on up to 85 percent or more of the premium dollar in our GAAP revenue, and manage that care, manage and assume additional risk, and reap the rewards that may come if we are able to manage those costs effectively.

You can see in the graph below that there are incredible amounts of opportunity for us to move patients along the risk ladder track from something as simple as fee-for-service to varying levels of risk such as professional risk, full risk, and finally all the way to that 85 percent of premium global risk track.

I won't go into the details here, but there are a lot of very tactical things that we can do that we have clear line of sight into to spur that 30 percent plus growth over the next 5 to 10 years.

Growth is only one part of the equation. It's easy to grow membership. You can offer them things. You can give them free tools. You can make it very attractive for providers to join your network. What really matters at the end of the day is to not only grow, but to manage the risk that you're taking as you grow effectively. That's something that we think we are truly differentiated in in terms of our clinical model and the outcomes that are effectuated by that clinical model.

For example, you can see here that in our Medicare Advantage lines of business, we're consistently under CMS benchmarks in inpatient bed days, in emergency room visits, and readmission rates. That doesn't stop only in an HMO construct.

Many think that utilization management or denials are the way that one might be able to control the medical expenditures of a population. But we see very similar results even in our ACO, original Medicare patients, where they can see any provider in the nation that accepts Medicare—consistently lower than benchmark in terms of inpatient bed days, emergency room visits, and readmission rates.

We do this across a very diverse set of patients. Not only are they diverse in terms of walk of life, in terms of line of business, in terms of age, but they're also very diverse in terms of ethnic or demographic background.

Brandon Sim: We truly think that the clinical model is agnostic of any of these characteristics. It's something that we feel we have a moral and financial imperative to scale across the country in local communities throughout the country.

I'd like to end by summarizing some of the points that I went over today.

We have a very clear path towards nationwide expansion by landing in a new geography, by creating a primary care network, building specialists and facilities around it, supporting them with our infrastructure, and filling in the gaps with our care teams. That's led to a 25 to 26 percent three-year revenue CAGR, as well as gives us clear line of sight into 30 percent plus growth over the next few years.

Secondly, we have a proven track record of being able to manage that risk once we've grown. We were the number one accountable care organization in the country among analogous ACOs and gross shared savings for CMS over the past two years. The third year before that, we were fourth in the nation.

We've got a flexible, very capital-efficient model with very predictable unit economics. 80 percent of our revenue is paid in a subscription-based model where we are paid a per member per month fee. That's something we can predict very easily and sustainably going forward. Our unit economics are also very predictable. Once all the costs are taken out, once all the admin is taken out because of our focus on automation, we've been very consistent in having 14 to 17 percent adjusted EBITDA margins over the last three years, exactly in the middle of our guided range of 10 to 20 percent long-term adjusted EBITDA margins.

Our technology powered integrated care delivery model has been proven to lead to extremely high-quality clinical outcomes demonstrated by our number of bed days, ER visits, and readmission rates.

Finally, most importantly to me, what gets me up each and every morning, is that we feel we are extremely strongly positioned to create a future in which all Americans can have access to high-quality, value-based, and evidence-driven healthcare.

With that, I'd like to open up the floor to questions. Chan and myself will be here to answer anything that you might be curious about. Thank you.

[applause]

Ethan Taylor: We have a mic runner in the room, so if anyone has questions, feel free to raise your hand and he'll direct it. I can kick things off for one question. Could you maybe expand a bit more about your forward-looking growth?

The number you said 30 percent, where's that coming from in terms of the mix of inorganic versus organic members and then between the two levers of shifting to high risk versus just growing membership?

Brandon Sim: Absolutely. That 30 percent number we talked about doesn't include inorganic growth at all, other than deals that we've already announced, the small tuck-ins in Nevada and Texas and here in San Francisco.

That 30 percent plus growth is really driven by the combination, the product of those two levers that I talked about earlier, growing membership and taking additional risk on that membership. We're seeing a very strong annual enrollment period, which just ended. There's open enrollment that continues, and we're seeing very encouraging membership numbers.

I would say that probably half of that contribution is from pure number of membership growth, another half from taking on a higher blended per member per month revenue on those existing members that we have, those 1.3 million members. If there is any incremental M&A in our pipeline, that would be additive to the 30 percent.

Ethan Taylor: Thank you. Then is there any update in the coming year regarding the Knox-Keene license?

Brandon Sim: That acquisition was announced, the definitive agreement was announced. We are still pending regulatory approval. I think we had guided to late Q1 of this year, so we think we're still on track there.

Ethan Taylor: Thanks.

Audience Member: How much of the growth do you, or maybe current state own center versus affiliate, and then where do you foresee the future growth path?

Brandon Sim: That's a great question. Another part of the difference in our model is that not only are we payer agnostic, but we're also agnostic to the care delivery entity that is providing the care, whether it's one of our employee W2 doctors or if it's an affiliate doctor, 1099 doctor.

The technology platform doesn't really care whether the doctor's employed by us or not. Of course, there's additional overhead we incur, benefits we incur from owning and operating a clinic. We have to hire the front office, hire the receptionist, hire the MAs, PAs, whatever it is. There are some benefits with that. Of course, we can control the EHR that they're on. We can be a little more integrated in terms of clinical programs and what we can really drive downstream to provider behavior.

To answer your question, outside of California, we think that it's going to be primarily driven by own-and-employed model growth to really have a solid foundation before we start building out that affiliate network outside of those clinics ex California. In California, I think it's still going to be primarily driven by affiliate model growth. We feel very comfortable with the footprint we have. We're very comfortable with managing care and managing medical costs in the affiliate model in California. I think that's not going to change dramatically, although we, of course, are building facilities where necessary to support the demand for healthcare.

Happy to take additional questions if you'd like, or if not, I'll come back to you.

Ethan Taylor: We can give it a moment or two. I'll have one final question from my end, and then I'll welcome any more. You talked about some very impressive utilization

numbers that you guys have. What trends are you seeing in that area, and do you see any significant changes moving forward?

Chan Basho: From '21 to '22, we have seen a slight increase in terms of our utilization. We're seeing it very much flat line, and as we go into '23, we don't see any large increases.

Ethan Taylor: Got it. Thank you.

Audience Member: I was wondering if you'd talk a little bit about the competitive landscape in terms of who you view as your direct competitors, particularly when you think about moving into the non-California markets.

Brandon Sim: I think this is an interesting space at the time. People have been talking about all sorts of things at this conference and outside of it. I think we have a differentiated product. There are a lot of competitors who are focused on a particular line of business only. Medicare is a very common one to be focused on, and that really makes it difficult for a provider to serve families that come in, to serve communities that they're embedded in inside.

While some of the peers in the space, I think we have a slide on it later in the appendix, Privia, agilon, CareMax, etc., we have a great deal of respect for all those models, but we think that the flexibility our model provides, the demonstrated track record of actually managing medical costs, the focus on not only primary care, which is obviously extremely important, but also on integrating specialty care into that healthcare ecosystem to really manage medical costs overall and the clear path of growth that we have set us apart from some of the peers. Hopefully that helps. Chan, do you want to elaborate?

Chan Basho: The only thing I would add on is our unique tech capabilities plus our MSO capabilities plus our ability to take on delegation in the non-California markets makes us very unique. Focusing on an owned PCP base and building off of that with an affiliate network, I think it marries together our California model as well as a non-California model as we expand.

Audience Member: Can you just talk about the M&A landscape and what are some of the criteria you look at when you're evaluating a company to acquire? Thanks.

Brandon Sim: 2022 was a challenging year in terms of an M&A. Macro landscape obviously looming large in everyone's minds, but still the trailing 12-month highs being a little too high to really cross the bid-ask spread in a meaningful way.

You can see in the financials we're sitting on cash. We're barely levered, if any. We've been keeping a lot of dry powder to ensure that when valuations come to somewhere we find reasonable, that we can underwrite a purchase, that we have the availability of dry capital to do that. Obviously, our banking partners here are very helpful in that regard. I think the pipeline is very strong to answer your question.

We'll continue to see that in 2023 as the wave of consolidation continues and folks try to figure out where their assets are best utilized. We think our flexible

and of all models, infrastructure is a nice landing place potentially for a lot of these assets. We're pretty busy in terms of the pipeline.

Chan Basho: Tony, just to add, beyond the, of course, financial considerations, a lot of it's the value that we can bring to the asset and then along with that the growth potential. For example, what made the Nevada asset very unique along with its facilities in Texas was the fact that we could bring all of our overall MSO capabilities, build out the IPA and really expand beyond that. Then also the growth potential in terms of our members moving from Los Angeles, Inland Empire to Nevada.

Ethan Taylor: If that's all, we'll give you some time back. Thank you again for the wonderful presentation. Thanks, everyone.

Brandon Sim: Thanks, everyone. Appreciate it.

Chan Basho: Thank you.

[applause]