Vitasora Health Ltd

VHL.AX

MST Access
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VHL: Measuring care mandatory? Remote monitoring core to US…

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NEED TO KNOW: Underserviced market; growing 11.2%

- 48% of Americans are covered by health plans where delivery of care is measured by outcome/cost. US Medicare will target 100% by 2030
- VHL provides **remote patient monitoring (RPM)**: device & human-led monitoring of care compliance, driving reduction in admissions/waste. Industry ripe for consolidation

US must deliver quality care at lower cost, here's why: The US healthcare system faces an unsustainable fiscal trajectory. In 2022, health spending reached US$4.5tn, or 17.3% of US GDP; it is projected to hit 20% by 2032. Hospitals make up 30% of costs.

RPM Solution mandated? 48% or 162m Americans are covered by **value-based care (VBC)** where health plans use "risk-sharing" in care purchase & provision, measured by quality & cost of outcomes. Accountable Care (ACOs), capitation & bundled payment systems are examples. 'Risk' drives better management of chronic care & reduction of unplanned admissions/waste. US Medicare (CMS) aims to transition all beneficiaries to VBC by 2030. RPM is core to compliance, clinical decisions & payment.

Pivot to Opportunity: Vitasora Health (VHL.AX) - previously Respiri - has pivoted from it's single 'Wheezo' asthma monitoring device to a full-service Connected Care Management company focused on RPM. The platform is device agnostic, and now includes human case-management & follow-up.

Investment Thesis: Key Challenge/Opportunity – Execute

Total Addressable Market (TAM): Regulatory tailwinds, cost pressures, and demographics are expected to drive a US TAM for RPM of US$30bn by 2030 (11.2% CAGR). RPM is fragmented & ripe for consolidation. VHL is building a solid contract base & poised to capture share as adoption accelerates.

Accelerating execution: Current VHL contracts fall into 4 core services, each with a fee structure for RPM service: (1) Data to Doctor & VHL get a fixed fee (equal to % of CPT code fee) for monthly service; (2) same as (1) but VHL manage billing/claim; (3) Discharge care model – VHL paid fixed fee (equal to % bundled payment); (4) Capitated model where the ACO pays for oversight of entire patient population. VHL's flexible fee-for-service and risk-share models accommodate other servicing models.

Direct Play on Value-Based Care: VHL is a data provider behind 'AI to the US healthcare system'. VHL now has key infrastructure in place, 6,500 patient programs 'in-service'. The key challenge is scale. VHL needs to execute; 'on-board' sites/patients. MSTe VHL can grow to 18,000+ patients FY27 end, generating revenue of A$30m at 50% gross margin.

Valuation/Risks: MST values VHL at A$0.12cps using DCF

Key Assumptions (DCF in detail at page 39): (1) FCF positive FY30 on modest patient growth target. (2) Cash balance of A$2.2m end of Mar-25 with A$1.6m due Jun-25, qrtrly cash burn ~A$2.6m, implies a runway of <2 qtrs.

Key Risks: Growth & execution (onboarding sites/patients) key challenge; scaling of costs, & hitting breakeven vs fixed costs to deliver positive CF.

Vitasora's care management model enables healthcare organisations to deliver remote patient monitoring, virtual clinical support, and AI-based decision tools outside traditional clinical settings. The approach aims to improve patient engagement and compliance, reduce healthcare system costs, and aligns with CMS policies supporting value-based care.

Valuation	**0.120**
Current price	**0.043**
Market cap	**A$75m**
Cash on hand	**A$2.2m**

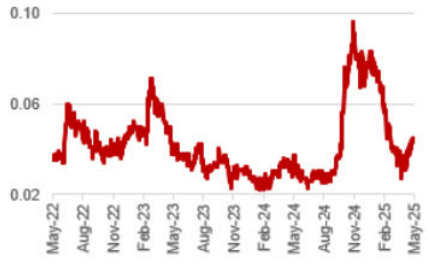
Additional Resources

Vitasora Health

Upcoming Catalysts / Next News

Period	
Ongoing	Growing the Client Pipeline
Ongoing	Convert Pipeline to Patient Programs
MidCY25	Wearable Device FDA Submission
Q4CY25	Annual Wellness Visit Service Launch
FY27	Management Guidance Targets

Share Price



Source: FactSet, MST Access

Contents

Figure 1: Financial Summary

Year end Dec	Units	FY23	FY24	FY25E	FY26E	FY27E
PE	**x**	**nm**	**-5.7**	**-8.3**	**-30.1**	**22.5**
EV/EBITDA	x	nm	-10.4	-11.1	-40.3	15.7
EV/EBIT	x	nm	-10.3	-11.0	-34.4	18.0
Div yield	%	0.0%	0.0%	0.0%	0.0%	0.0%
FCF yield	%	-6.1%	-8.9%	-15.4%	-14.8%	-10.5%

Stock information	
Ticker	**VHL.AX**
Share Price ($)	0.04
Target price ($)	0.12
Enterprise value (A$m)	73
Market capitalisation (A$m)	75

Income statement	Units	FY23	FY24	FY25E	FY26E	FY27E	1H24	2H24	1H25	2H25E	1H26E	2H26E
Revenue (Incl other income)	**A$m**	**0.7**	**1.0**	**4.9**	**16.1**	**29.2**	**0.7**	**0.3**	**1.5**	**4.0**	**6.6**	**9.5**
growth y/y	%	*0.0%*	*0.0%*	*375.5%*	*227.3%*	*81.1%*	*0.0%*	*0.0%*	*111.0%*	*1193.7%*	*326%*	*nm*
EBITDA	**A$m**	**-5.7**	**-7.0**	**-6.6**	**-1.8**	**4.7**	**-3.0**	**-4.0**	**-3.6**	**-2.9**	**-1.5**	**-0.4**
EBITDA margin	%	*-864.5%*	*-677%*	*-133%*	*-11%*	*16%*	*-416%*	*nm*	*-235%*	*nm*	*-22%*	*nm*
EBIT	**A$m**	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**4.1**	**-3.1**	**-3.9**	**-3.6**	**-3.0**	**-1.7**	**-0.5**
EBIT margin	%	*-876.3%*	*-683%*	*-135%*	*-13%*	*14%*	*-429%*	*nm*	*-237%*	*nm*	*-26%*	*nm*
PBT	**A$m**	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**4.1**	**-3.2**	**-3.9**	**-3.6**	**-3.0**	**-1.7**	**-0.5**
PBT margin	%	*-877.9%*	*-689%*	*-135%*	*-13%*	*14%*	*-437%*	*nm*	*-237%*	*nm*	*-26%*	*nm*
NPAT	**A$m**	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**2.8**	**-3.2**	**-3.9**	**-3.6**	**-3.0**	**-1.7**	**-0.5**
NPAT margin	%	*-877.9%*	*-689%*	*-135%*	*-13%*	*10%*	*-437%*	*nm*	*-237%*	*nm*	*-26%*	*nm*
Reported NPAT	**A$m**	**-5.8**	**-7.2**	**-6.5**	**-2.0**	**3.0**	**-3.3**	**-3.9**	**-3.6**	**-2.9**	**-1.6**	**-0.4**
Reported NPAT margin	%	*-878.0%*	*-693%*	*-132%*	*-12%*	*10%*	*-452%*	*nm*	*-232%*	*nm*	*-24%*	*nm*

Per share data	Units	FY23	FY24	FY25E	FY26E	FY27E	1H24	2H24	1H25	2H25E	1H26E	2H26E
Average diluted shares	m		1,018	1,373	1,600	1,600	905.6	1,129.7	1,212.8	1,533.8	1,600	1,600
EPS	**cps**		**-0.7**	**-0.5**	**-0.1**	**0.2**	**-0.4**	**-0.3**	**-0.3**	**-0.2**	**-0.1**	**0.0**
growth y/y	%		*nm*	*nm*	*-72.4%*	*-233.5%*	*0.0%*	*0.0%*	*-14.7%*	*-44.2%*	*-65.1%*	*-85.5%*
Reported EPS	**cps**		**-0.7**	**-0.5**	**-0.1**	**0.2**	**-0.4**	**-0.3**	**-0.3**	**-0.2**	**-0.1**	**0.0**
growth y/y	%		*nm*	*nm*	*-73.6%*	*-249.3%*	*0.0%*	*0.0%*	*-19.1%*	*-47.7%*	*-65.9%*	*-86.4%*
DPS	**cps**		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Payout ratio	%		*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*

Balance sheet	Units	FY23	FY24	FY25E	FY26E	FY27E
Cash	A$m	0	1	-1	-12	-20
Trade receivables	A$m	0	0	6	15	25
Inventories	A$m	3	3	2	2	3
Property, plant & equipment	A$m	0	0	0	0	0
Right-of-use assets	A$m	0	0	0	0	0
Goodwill	A$m	0	2	2	2	2
Intangibles	A$m	0	0	0	0	1
Other assets	A$m	0	0	0	1	1
Total assets	**A$m**	**3**	**6**	**10**	**8**	**11**
Trade payables	A$m	2	2	2	3	3
Provisions	A$m	0	0	0	0	0
Borrowings	A$m	0	1	0	0	0
Lease liabilities	A$m	0	0	0	0	0
Other liabilities	A$m	0	0	0	0	0
Total liabilities	**A$m**	**2**	**4**	**3**	**3**	**3**
Total equity	**A$m**	**1**	**3**	**7**	**5**	**8**
Invested capital	A$m	1	3	8	17	28
Net debt (pos)	**A$m**	**0**	**0**	**1**	**12**	**20**

Performance metrics	FY24	FY25E	FY26E	FY27E
ROE (%)	-541%	-141%	-37%	45%
ROIC (%)	nm	nm	nm	nm
Gearing (%)	14%	17%	72%	72%
Adj ND / EBITDA (x)	0.0	-0.1	-3.4	2.2
NWC (A$m)	1	6	15	25
NWC % of sales (%)	103%	120%	90%	85%
Gross OCF / EBITDA (%)	95%	173%	578%	-119%
Capex / sales (%)	0.0%	2.9%	3.6%	3.6%
P/FCF (x)	-11.2	-6.5	-6.7	-9.5
P/BV (x)	28.3	11.0	15.6	9.6

Cash flow statement	Units	FY23	FY24	FY25E	FY26E	FY27E
EBITDA	A$m	-6	-7	-7	-2	5
Change in NWC	A$m	0	0	-5	-9	-10
Other	A$m	1	0	0	0	0
Gross operating cash flow	A$m	-4	-7	-11	-10	-6
Net interest	A$m	0	0	0	0	0
Tax paid	A$m	0	0	0	0	-1
Operating cash flow	**A$m**	**-4**	**-7**	**-11**	**-10**	**-7**
Capital expenditure	A$m	0	0	0	-1	-1
Acquisitions	A$m	0	-2	0	0	0
Asset sales	A$m	0	0	0	0	0
Other	A$m	0	0	0	0	0
Investing cash flow	**A$m**	**0**	**-2**	**0**	**-1**	**-1**
Net borrowings	A$m	0	1	0	0	0
Dividends paid	A$m	0	0	0	0	0
New shares issued / other	A$m	3	8	9	0	0
Financing cash flow	**A$m**	**3**	**9**	**9**	**0**	**0**
Net change in cash	**A$m**	**-1**	**1**	**-2**	**-11**	**-8**
Free cash flow	**A$m**	**-5**	**-7**	**-11**	**-11**	**-8**

Source: VHL, MSTe

Investment Case: Vitasora Health (VHL.ASX)

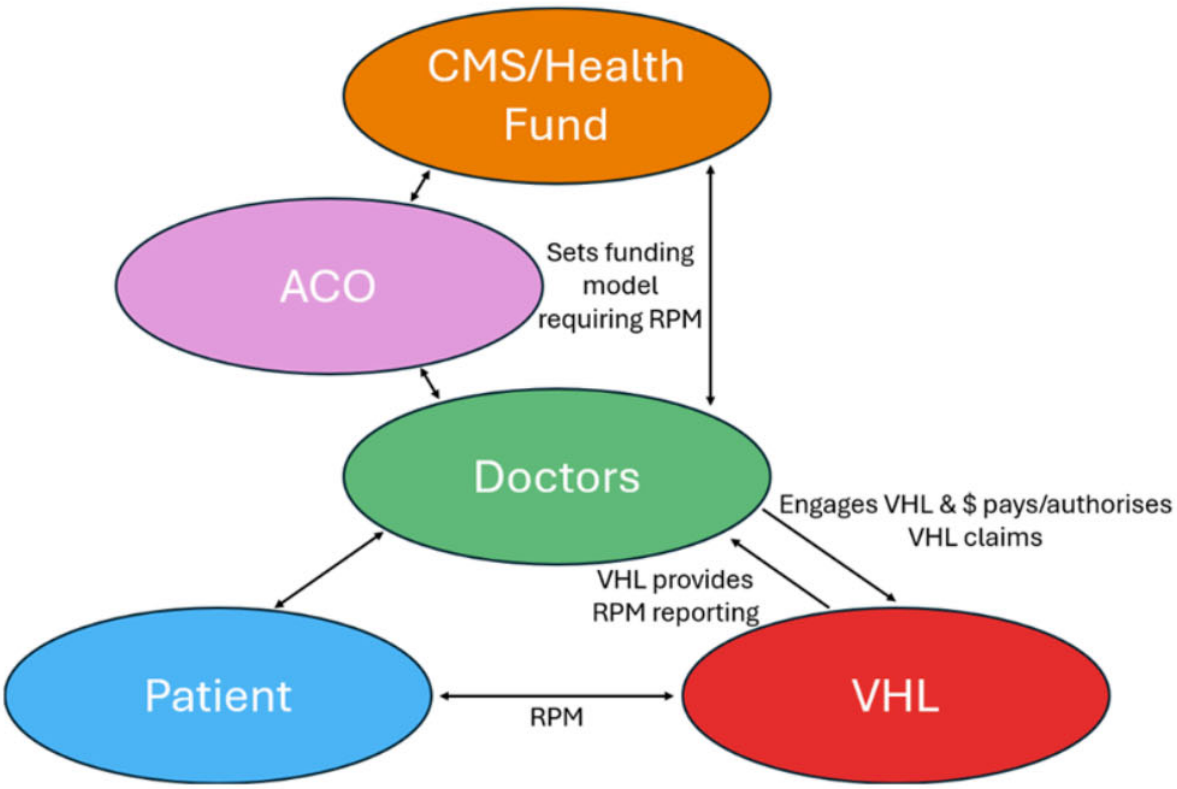
Investment Thesis:

- **US Spend & Reform:** Healthcare is 17.3% of US GDP; it is projected to hit 20% by 2032 & must deliver quality care at lower cost. Some 48% of Americans are now covered by Value Based Care (VBC) where "risk" is shared across the purchase, provision, and quality of health outcomes – risk sharing takes the form of Accountable Care (ACO's), capitation & bundled payment systems.
- **Patient Data:** Is integral to clinical decisions & payment under these models. Here, Remote patient monitoring (RPM) is critical, particularly in chronic care & reduction unplanned admissions/waste.
- **Unique Exposure:** VHL is the only ASX-listed entity that provides exposure to RPM – industry TAM is projected to reach US$30bn by 2030 (11.2% CAGR). RPM market is currently fragmented & ripe for consolidation.
- **Opportunity & Challenges:** VHL now has key infrastructure in place, 6,500 patient programs 'in-service'. The key challenge is scale. VHL needs to execute; 'onboard' sites/patients.
- **Valuation:** MSTe VHL can grow to 18k+ patients by FY27, generating revenue of A$30m at 50% gross margin. Using DCF our implied valuation is $0.12cps.
- **Targets:** VHL has set itself more ambitious targets (30k patients by start FY27); if achieved implies material valuation upside with incremental margin.
- **Risk:** Execution and scale is key near term challenge.

Background - Strategic pivot to Connected Care Management

Vitasora Health (VHL.AX) - previously Respiri - has pivoted from its single 'Wheezo' asthma monitoring to become a full-service commercial-stage Connected Care Management company. VHL is focused on remote patient monitoring (RPM). The platform is device agnostic and offers human case-management & follow-up. The platform is compliant with the Centres for Medicare and Medicaid (CMS).

Figure 2: Simple outline of the relationship of VHL to Patients, Doctors and Reimbursement entities



Source: VHL Notes: In capitated models VHL might directly contract with the ACO

What is VHL's Platform and Offer

VHL has developed a device-agnostic connected care management platform. Its technology integrates various connected medical devices, via Bluetooth or cellular transmission, with VHL's remote patient monitoring (RPM) software. The platform is now built to provide for human case-management & follow-up.

Post Doctor or Insurer permissioned engagement, VHL 'on-boards' patients, broadly as follows:

- Device to remotely monitor patients (cost US$60 per device as COGS, typically only 1 required)
- Human concierge follow-up for at least 20mins (cost US$24/hr, as required)
- Compliant data storage & reporting to Doctor for action
- Payment to VHL (monthly) – via invoice to Doctor (under fixed fee-for-service or direct billing to CMS/Insurer via cloud; equal to a % bundled payment)

Human-to-human 'nudges' improve healthcare compliance, especially for seniors

MST reviewed a series of US studies in quality journals. The studies are consistent in showing that human-to-human nudges, especially phone calls, significantly improve medication adherence, appointment attendance, and preventive care compliance. Human interventions are particularly effective among older adults and those needing extra support, though they require more resources than automated approaches.

Two key elements for offer and payment:

As a Connected Care Management company, VHL offers Doctors and Reimbursement entities:

1. a capabilities 'menu'; and
2. revenue model which fits different payment mechanisms.

1. VHL capabilities menu –

VHL uses remote care in therapy compliance monitoring, with clinical escalation of urgent cases to treating physicians. All services below are billable under distinct CPT codes (detailed further in Appendix A):

- **Remote Patient Monitoring (RPM) -** Uses medical devices (e.g. blood pressure monitors, glucose meters) to track physiological data remotely, enabling real-time health insights and early intervention.
- **Chronic Care Management (CCM) -** Provides ongoing care coordination for patients with multiple chronic conditions, ensuring better disease management through regular check-ins and care plans.
- **Principal Care Management (PCM) -** Similar to CCM but designed for patients with a single high-risk chronic condition, requiring intensive monitoring and management.
- **Remote Therapeutic Monitoring (RTM) -** Monitors non-physiological data (for example, medication adherence, therapy effectiveness, respiratory/musculoskeletal conditions) using digital tools to improve therapeutic outcomes.
- **Transitional Care Management (TCM)** - Supports patients transitioning from inpatient care to home, focusing on follow-ups, medication management, and reducing hospital readmissions.

2. Revenue model to fits different payment mechanisms –

1. **Fee-for-Service:** Data to Doctor & VHL get paid a fixed fee (equal to a % of CPT code fee for monthly service);
2. **Fee-for-Service (Clinic-in-Cloud):** Broadly same as (1) but VHL manage billing/claim using cloud-based system;
3. **Discharge care model:** VHL paid % bundled payment
4. **Capitated model** where the ACO pays for the entire patient population. VHL's flexible fee-for-service and risk-share models accommodate other servicing models.

VHL contracts fall into 4 core services, each with clear fee structure for its RPM service:

Figure 3: How does VHL get paid? Fee-for-service and risk-share revenue model models accommodate other servicing models

Service Model	*Monthly Fee Per Patient (PPPM)*	*% to VHL*
Fee-for-Service (Traditional)	US$70–100	Fixed; equal to 60% of CPT fee
Fee-for-Service (Clinic-in-Cloud) (VHL manage billing/claim using cloud-based system)	US$130–190	Fixed; equal to 60–95% retention
Discharge Care (Bundled Payment)	Bundled payment-based (N/A)	% of savings
Risk-Share (Value-Based)	US$10–40 base + $160–250 shared savings	Shared savings %
Other: Annual Wellness Check	N/A	N/A

Source: VHL Notes: % to VHL, explicit percentages are only defined for Models 1 and 2. Models 3 and 4 involve variable shares (e.g., bundled savings or risk-sharing). CPT Updates: Proposed AMA changes could boost revenue for Models 1 and 2 by $70–90PPPM. Shared Savings: Model 4's upside depends on engagement rates (8–15% for high-risk patients) and measurable cost reductions.

Key Challenge & Opportunity – Execution

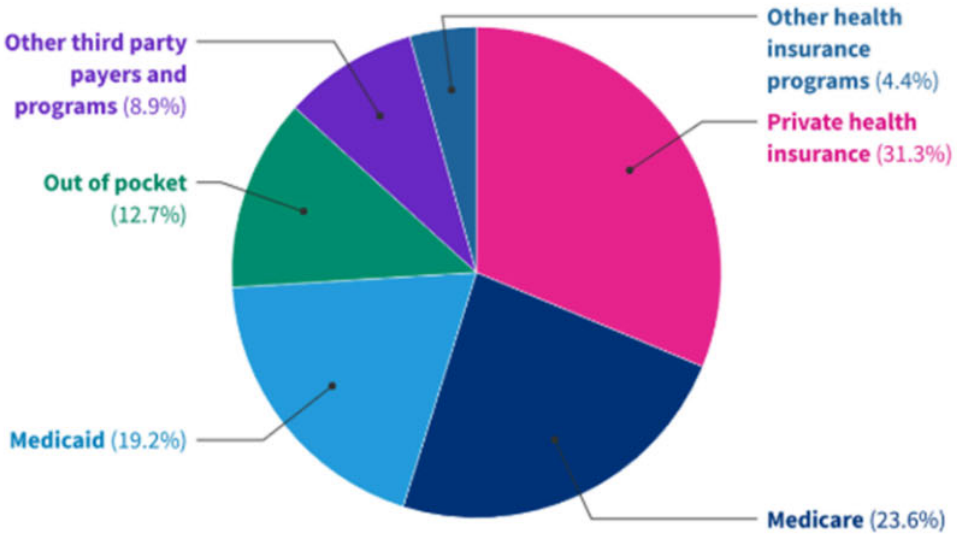
VHL has key infrastructure is in place, 6,500 patients 'in-service' & key challenge is scale. We make the following observations on the challenge and opportunity:

- VHL needs execution; on-boarding practices & 'patients under management'. Each site consumes 4-5hrs of 'sales pitch' and conversion, with a 1 in 3 success rate.
- Primary Care Provider (PCP) practices are generally targeted where VHL is given a 'hunting licence' by ACO or Insurer to target practices within the group.
- MSTe VHL can grow to 18,000+ patients in 2yrs (FY27 end), generating revenue of A$30m at 50% gross margin.

Background – USA Health System

The US healthcare system is the world's largest, with **US$4.5tn in spending (17.3% of GDP)** in 2022, and projected to reach **20% of GDP by 2032.**

Figure 4: USA Healthcare Insurance Spending – by source of funds



Source: ACA

Components:

- **Medicare**: Federal funded for over +65 yr olds. Covers **~68m** people (~60m aged 65+, ~8m disabled). Includes Parts A (hospital), B (outpatient), C (Medicare Advantage), and D (drugs).
- **Medicaid**: Co-funded Federal/State run covering the socially vulnerable. Covers **~93m** low-income individuals, including Children's Health Insurance Program (CHIP).
- **Private / Commercial insurance**: Covered **~182m** including employer-sponsored (self-insured) plans and Affordable Care Act (ACA) marketplace coverage-remains (24m people enrolled in ACA marketplace plans for 2025).

Spending breakdown: Hospitals (30% of total Health system costs), physician services, drugs, and administrative overhead.

Growth outlook: Healthcare spending growth at 5.6% pa to outpace US GDP estimated at 4.3% pa through 2032, driven by aging population and chronic disease.

Across this coverage, some 162m Americans are now covered by value-based care (VBC) where health plans and providers to share responsibility ("risk") for health outcome costs and quality; examples include Accountable Care Organisations (ACO's), capitation & bundled payments.

Repositioning US Health from Fee-for-Service to Outcome/Quality based care

The US system faces **unsustainable costs** (US$4.5tn in 2022, 17.3% of GDP) and inefficiencies. **>50% of Americans** rely on Federally funded programs (Medicare/Medicaid), where fee-for-service rewards volume over outcomes.

Actions to curb spending and improve care, are continuing to expand:

- **Patient data is key in care compliance, clinical decisions & payment:** Remote patient monitoring (RPM) is integral, particularly in chronic care & reduction unplanned admissions/waste.
- **Core strategies:** Prevent unnecessary admissions, reduce waste, and shift care to alternate sites (e.g., home monitoring). Data-driven compliance and payment models are critical.
- **CMS objective:** Transition 100% of Traditional Medicare beneficiaries to accountable care (ACOs) by 2030, with 53.4% already enrolled as of 2025.

Background – What are ACOs/Medicare Advantage & focus on outcome/quality

VHL's Remote Patient Monitoring (RPM) is currently focussed on chronic disease management (such as diabetes, hypertension, COPD), post-discharge follow-up, and preventive monitoring to reduce hospitalisations and improve long-term outcomes.

Accountable Care Organisations (ACOs) are networks of doctors, hospitals, and other healthcare providers that take responsibility for the cost and quality of care for a defined group of Traditional Medicare beneficiaries. By participating in shared savings models, ACOs are incentivised to coordinate care, reduce unnecessary services, and improve outcomes. Studies have shown that ACOs can reduce hospitalisations by 9 to 44% for chronic conditions.

- **ACOs are evaluated on their ability to coordinate care across providers and settings:** ACOs have demonstrated reductions in hospital readmissions-outperforming non-ACO hospitals-and consistently show improvements in quality scores, patient experience, and adherence to treatment plans.
- Some **ACOs participate in capitated payment models**, such as the Next Generation ACO's All-Inclusive Population-Based Payment, which gives them a fixed per-patient payment to manage population health and incentivises efficient, high-quality care delivery.

Medicare beneficiaries may opt to enrol in commercially managed advantage (MA) plans – Already >50% of Medicare beneficiaries have switched. MA essentially delivers a value-based care (VBC) arrangement, receiving a fixed monthly payment per enrolee to cover all Medicare benefits.

- **Plans are motivated to manage costs and improve quality**, as their revenue depends on keeping members healthy and avoiding unnnecessary care. Recent data show that MA outperforms fee-for-service, with ED visits down -11%, readmissions down -9%, and chronic disease management, reflecting more effective preventive care and care coordination.

- **MA plans use star ratings (4+ stars for bonuses)** and risk-adjusted payments to incentivise quality.Medicare Advantage plans are rated on a five-star system based on over 40 measures, including preventive care, chronic disease control, patient satisfaction, and administrative performance. Plans earning four or more stars receive financial bonuses and can offer enhanced benefits, creating strong incentives to maintain high quality. Risk-adjusted payments further reward plans for effectively managing higher-risk populations.

VHL is essentially aiming to be a key data provider behind the 'AI' which will measure patient compliance, outcomes to shape clinical decisions & payments, and underpin the evolution of the US healthcare system.

RPM is fragmented & ripe for consolidation

Leading RPM providers include Teladoc Health, Biofourmis, HealthSnap, AMC Health, and CareSimple, each offering varying levels of clinical integration, device capabilities, and Medicare alignment. Notably, Rural Health Clinics have become eligible to bill for RPM services starting in 2025, expanding access in underserved areas.

Total Addressable Market (TAM)

The RPM market is experiencing rapid growth, projected to expand from US$18.4bn in 2025 to US$30bn by 2030 (at a 11.2% CAGR). This is fuelled by the rise of chronic disease, an ageing population, increasing Medicare alignment, and supportive CMS reimbursement policies.

Financials

Key costs include medical devices (US$60/one-time per patient), set-up costs (US$2/one-time per patient), SaaS fees (US$4PPPM), cellular fees (US$1PPPM) and clinical staff costs (US$24/hr). Where PPPM = per patient per month.

Key Assumptions

As at Mar-25 quarterly, cash balance of A$2.2m, with A$1.6m cash due in Jun-25 (second tranche of capital raise) and revenue of A$1.1m.

Current qtrly cash burn of ~A$2.6m implies a runway of <2 qtrs of cash. However, current cash burn reflects increased costs from the acquisition of Orb Health before cost synergies. MST has not modelled a capital raise, but the cash position would infer that a capital raise is likely in the future.

MSTe VHL can grow to 18,000+ patients FY27, generating revenue of A$30m at 50% gross margin.

Valuation: MST values VHL at A$0.12cps

MST values VHL at A$0.12cps using an DCF on future earnings (current share price A$0.04cps). Further detail on financials plus valuation methodology & assumptions pages 35-39.

We flag that our DCF model is sensitive to the Sales Pipeline, Patient Programs and the distribution amongst the types of capabilities/revenue models on offer.

VHL provides quarterly cashflow data which will offer validation of VHL's progress.

Key Risks

- Revenue is still modest, execution (onboarding sites/patients) is the key challenge; scaling of costs, breakeven vs fixed costs to deliver positive CF.
- The 'law of small numbers' leaves a minimal margin for error and VHL may require additional funding.
- Insufficient patient volume risks negative operating leverage and delayed profitability.
- Revenue depends on CMS reimbursement and CPT codes; policy changes could disrupt growth.
- Integration with diverse EMR systems creates onboarding and workflow challenges.
- VHL's progress in enrolling sites will offer validation of the business model and expansion of contracted revenues.
- Provider or staff engagement friction may slow scaling and adoption.
- Competitors could outpace VHL on automation or pricing.
- Cybersecurity and compliance risks are significant due to health data handling.

Key pivotal events / dates / catalysts

- Ongoing – Growing the Client Pipeline
- Ongoing – Converting the Pipeline to Patient Programs
- MidCY25 – Wearable Respiratory Device FDA Submission
- Q4CY25 – Annual Wellness Visit Service Launch
- Start FY27 – Operating CF Breakeven in the next 12-18mths (Management Guidance Target) vs MSTe 2HFY29
- Start FY27 – 30,000 patients in the next 12-18mths (Management Guidance Target) vs MSTe 2HFY29

Vitasora (VHL.AX) In Detail

What does VHL do?

VHL delivers proactive, preventive care for chronically ill patients through an integrated remote monitoring and care coordination platform, underpinned by the philosophy that "a patient monitored is a patient reminded". Continuous monitoring reinforces behavioural adherence and drives clinical stability, ensuring patients remain engaged in their care.

Human-to-human 'nudges' improve healthcare compliance, especially for seniors

MST reviewed a series of US studies in quality journals. The studies are consistent in showing that human-to-human nudges, especially phone calls, significantly improve medication adherence, appointment attendance, and preventive care compliance. Human interventions are particularly effective among older adults and those needing extra support, though they require more resources than automated approaches.

Findings from study review:

1. **Medication Adherence:** Patients receiving calls had higher medication adherence rates at 6 months (statistically significant improvement), and reduced hospital readmissions (JAMA)
2. **Appointment Attendance:** Impact of phone call reminders on primary care appointments findings: no-show rates dropped 26% vs no reminder (AJM)
3. **Cancer Screening Compliance:** Non-clinical staff called patients overdue for screening, provided education, and offered to schedule appointments; screening rates increased by up to 12% in the intervention group compared to usual care. (Ann Fam Merd)
4. **Vaccination Uptake:** Telephone reminders for Influenza Vaccination: Automated and live phone reminders for flu shots; live calls were more effective, especially among older adults. (AJPH)

Why Are Phone Calls Effective?

- **Personalised Care:** Staff can address specific patient concerns and answer questions.
- **Trust and Rapport:** Human interaction builds confidence and motivation.
- **Clarification:** Patients receive clear instructions and can resolve logistical issues in real time.

Challenges:

Resource Intensive: Requires staff time and funding.

Scalability: More difficult to implement for large populations compared to automated reminders.

Vitasora RPM capabilities

All services below are billable under distinct CPT codes (detailed further in Appendix A):

Remote Patient Monitoring (RPM) - Uses medical devices (e.g. blood pressure monitors, glucose meters) to track physiological data remotely, enabling real-time health insights and early intervention.

Chronic Care Management (CCM) - Provides ongoing care coordination for patients with multiple chronic conditions, ensuring better disease management through regular check-ins and care plans.

Principal Care Management (PCM) - Similar to CCM but designed for patients with a single high-risk chronic condition, requiring intensive monitoring and management.

Remote Therapeutic Monitoring (RTM) - Monitors non-physiological data (e.g. medication adherence, therapy effectiveness, respiratory/musculoskeletal conditions) using digital tools to improve therapeutic outcomes.

Transitional Care Management (TCM) - Supports patients transitioning from inpatient care to home, focusing on follow-ups, medication management, and reducing hospital readmissions.

Vitasora revenue model (fits different payment mechanisms)

Current VHL contracts fall into 4 core services, each with clear fee structure for its RPM service:

1. **Fee-for-Service:** Data to Doctor & VHL get % of CPT code fee for monthly service;
2. **Fee-for-Service (Clinic-in-Cloud):** Broadly same as (1) but VHL manage billing/claim using cloud-based system;
3. **Discharge care model:** VHL paid % bundled payment;
4. **Capitated model** where the ACO pays for oversight of entire patient population. VHL's flexible fee-for-service and risk-share models accommodate other servicing models.

Figure 5: How does VHL get paid? Fee-for-service and risk-share revenue model models accommodate other servicing models

Service Model	*Monthly Fee Per Patient (PPPM)*	*% to VHL*	*Description*
Fee-for-Service (Traditional)	US$70–100	Fixed; equal to 60% of CPT fee	Providers outsource RPM to VHL VHL submits compliant data. Doctor pays VHL Doctor bills via CMS CPT codes.
Fee-for-Service (Clinic-in-Cloud) (VHL manage billing/claim using cloud-based system)	US$130–190	Fixed; equal to 60–95% retention	VHL manages end-to-end billing and captures own fee, balance paid to Doctor. Higher retention due to vertical integration.
Discharge Care (Bundled Payment)	Bundled payment-based (N/A)	% of savings	VHL monitors discharged patients to reduce hospital costs under bundled payment models (e.g., DIG).
Risk-Share (Value-Based)	US$10–40 base + $160–250 shared savings	Shared savings %	Fixed PPPM fee + shared savings for improved outcomes. Targets high-risk populations in Medicare Advantage.
Other: Annual Wellness Check	N/A	N/A	Prompts annual wellness checks to trigger risk assessments and monitoring eligibility.

Source: VHL Notes: % to VHL, explicit percentages are only defined for Models 1 and 2. Models 3 and 4 involve variable shares (e.g., bundled savings or risk-sharing). CPT Updates: Proposed AMA changes could boost revenue for Models 1 and 2 by $70–90 PPPM. Shared Savings: Model 4's upside depends on engagement rates (8–15% for high-risk patients) and measurable cost reductions.

Pathway from prospect to revenue

VHL employs a systematic process to acquire healthcare providers as clients and onboard eligible patients. The approach is designed to integrate seamlessly with the US healthcare ecosystem while addressing key challenges related to provider resources, reimbursement, and patient engagement.

Step 1: Provider Identification and Onboarding - The process begins with identifying suitable clients and conducting outreach before signing a commercial agreement with a HCO, typically a value-based care focused group such as an ACO, PCP or IPA.

Step 2: Signing the Client Contract - A HIPAA-compliant business associate agreement (BAA) is executed, granting VHL access to de-identified claims data and clinical utilisation information for retrospective analysis. This establishes the commercial framework for RPM implementation and reimbursement optimisation.

Step 3: Patient Cohort Stratification ("Go-Hunting") - Using claims data and VHL's in-house AI-enabled stratification tools, eligible patients are identified based on chronic disease status (e.g., COPD, asthma, diabetes), recent healthcare utilisation (ED visits, hospitalisations), and payer type. The focus is on Medicare and Medicare Advantage populations, with limited participation from Medicaid.

Step 4: Direct-to-Patient Engagement - On behalf of the provider, VHL's care coordination team conducts targeted outreach to identified patients to introduce the RPM program, obtain consent, and onboard them with remote monitoring devices (including the proprietary Wheezo and other chronic condition devices). Call centre support (e.g. via Orb Health) enhances reach and enrolment rates, alleviating administrative burden for clients.

Step 5: Payer-Based Population Segmentation - Patients are categorised by payer type to align care plans and reimbursement pathways. Medicare Fee-for-Service patients are eligible for RPM CPT codes, Medicare Advantage members generate higher capitation revenue, and Medicaid patients may be addressed where commercially viable.

Step 6: Initiation of Remote Monitoring and Care Management - Enrolled patients begin continuous monitoring. VHL's platform collects physiological and behavioural data, triggering real-time alerts and escalating urgent cases to clinicians in line with the patient's care plan. This supports compliant CPT billing thresholds and optimises clinical oversight. Post Doctor or Insurer permissioned engagement, VHL 'on-boards' patients, with VHL's offering being:

- Device to remotely monitor patients (cost US$60 per device as COGS, typically only 1 required)
- Human concierge follow-up for at least 20mins (cost US$24/hr, as required)
- Compliant data storage & reporting to Doctor for action
- Payment to VHL (monthly) – via invoice to Doctor (under fixed fee-for-service or direct billing via cloud; equal to a % bundled payment)

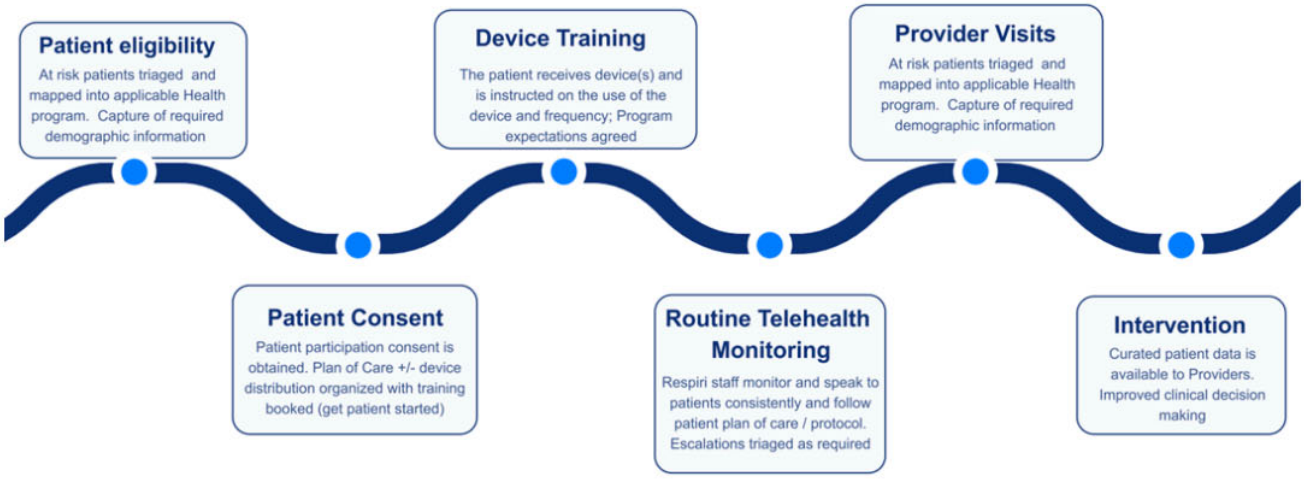
Step 7: Escalation Protocols and Clinical Intervention -

Non-adherent or deteriorating patients are flagged and escalated to the relevant provider for further review. This includes initiating telehealth consultations or in-person visits. VHL also supports Annual Wellness Visit (AWV) completion to improve coding accuracy and increase risk-adjusted revenue for payers and providers.

Step 8: Performance Reporting and Optimisation -

VHL provides transparent reporting to partner organisations, including RPM enrolment metrics, billing uplift, clinical outcomes, and engagement rates. These insights are used to optimise the program, refine targeting, and improve retention and shared savings performance over time.

Figure 6: A typical patient pathway with VHL



Source: VHL

Client target market for RPM programs

Presents a target rich environment (detailed further in Appendix A):

VHL's commercial strategy focuses on large-scale, syndicated provider groups where there is a strong alignment between chronic disease prevalence, value-based reimbursement incentives, and the need to reduce avoidable costs. Rather than targeting fragmented providers, VHL aims to secure contracts with integrated networks to maximise patient volumes and drive recurring revenue. Key targets are:

Accountable Care Organisations (ACOs) are mandated to manage total cost of care for Medicare populations. They are financially incentivised through shared savings to reduce hospitalisations and improve chronic disease management outcomes. VHL's ability to enhance RPM compliance, support hierarchical condition category (HCC) coding accuracy and improve AWV completion rates is highly attractive to ACO partners.

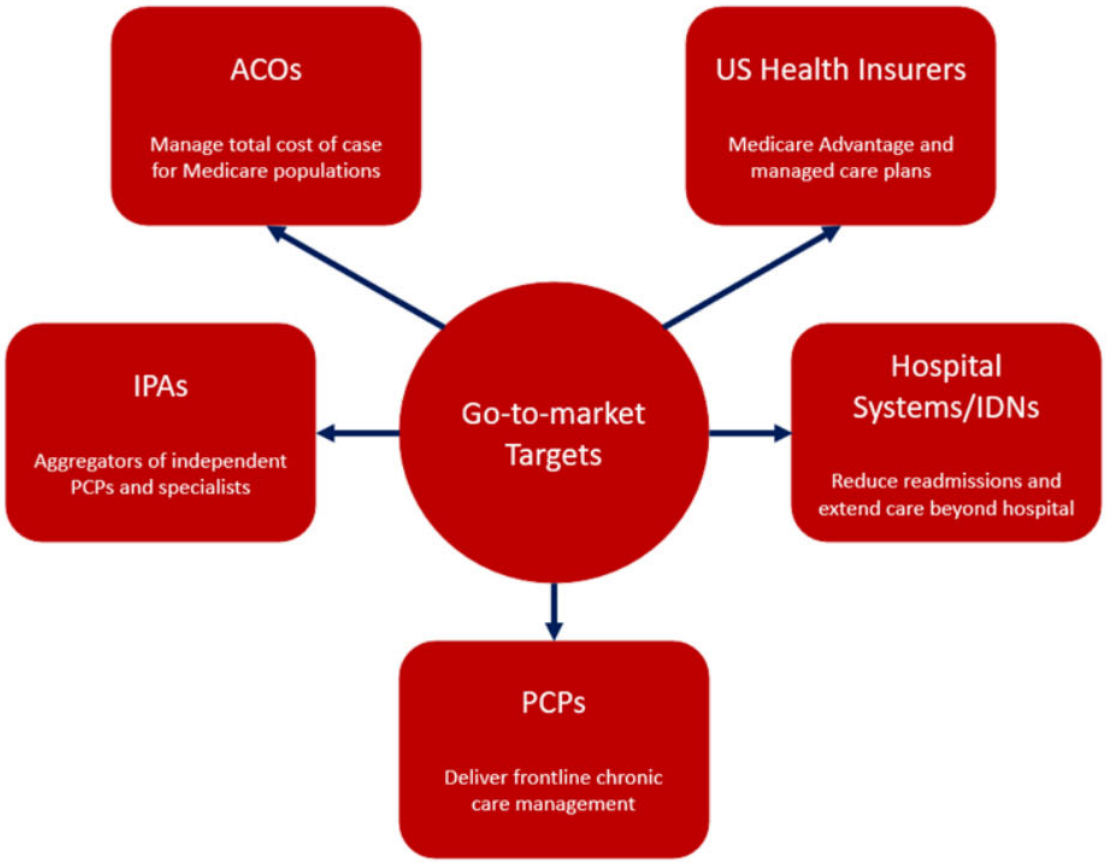
US Health Insurers (Medicare Advantage and Managed Care Plans) Payers operating capitated models benefit directly from reduced claims costs and improved risk scores. VHL's solution helps insurers optimise medical loss ratios, improve Star Ratings, and reduce avoidable high-cost events, making the platform highly complementary to their objectives.

Independent Physician Associations (IPAs) aggregate independent PCPs and specialists and increasingly need scalable solutions to meet VBC performance benchmarks. VHL's platform allows IPAs to roll out RPM and CCM programs without substantial technology investment, providing meaningful scale efficiencies.

Hospital Systems / Integrated Delivery Networks (IDNs) Hospitals are under pressure to reduce readmissions, particularly under CMS's Hospital Readmissions Reduction Program (HRRP). VHL supports post-discharge monitoring and reduces avoidable readmissions, helping hospital systems manage penalties, enhance patient throughput, and extend care beyond the hospital setting.

Primary Care Providers (PCPs) serve as the primary gateway to chronic care management but often lack infrastructure and resources to run compliant RPM programs. VHL's Clinic-in-Cloud model eliminates administrative barriers, providing a turnkey solution that enables PCPs to generate new revenue while improving patient outcomes.

Figure 7: Main client target market that host a network of Doctors



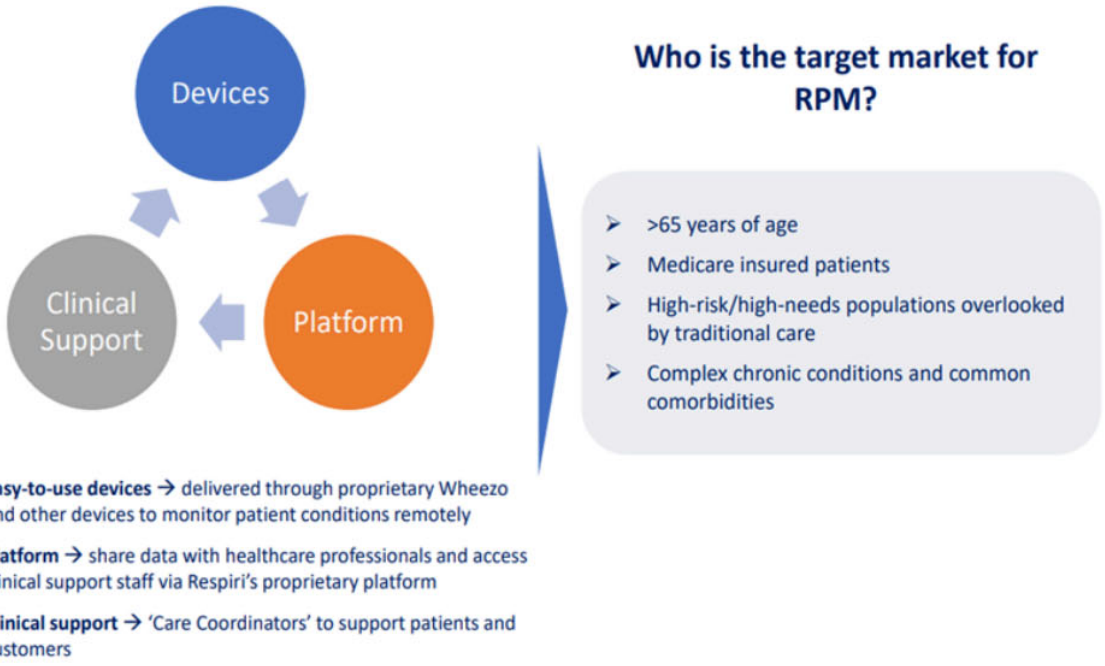
Source: MSTe

Patient target market for RPM programs

Characteristics of Ideal Patient Programs

- >65 years of age
- Medicare insured
- High-risk and high-needs populations overlooked by traditional 'reactive' care
- Complex chronic conditions and common comorbidities

Figure 8: VHL has a clear function, solution and patient target market



Source: VHL

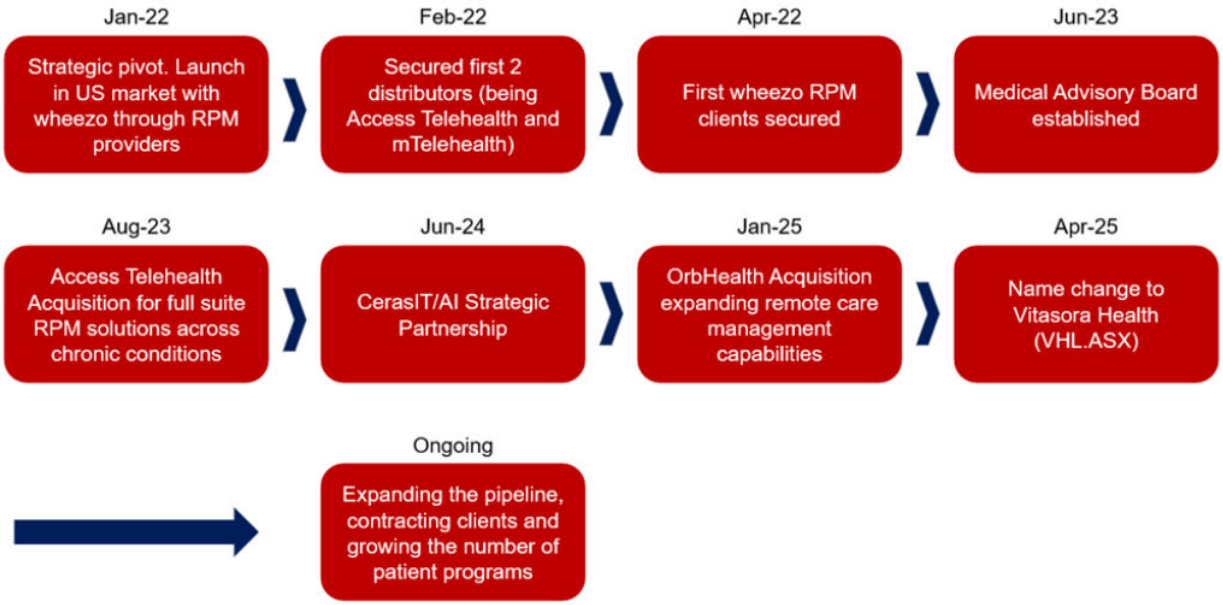
Relevant History and Key People

VHL began its strategic pivot in Jan-22 by entering the US market with its proprietary Wheezo device via RPM providers. Following the onboarding of distributors (Access Telehealth and Telehealth) and the acquisition of its first RPM clients, the company established a Medical Advisory Board by mid-2023.

In Aug-23, VHL acquired Access Telehealth to expand its RPM capabilities across chronic conditions. This was followed by a strategic partnership with CerasIT in Jun-24 and the acquisition of Orb Health in Jan-25, further enhancing care coordination.

The company officially rebranded to Vitasora Health (VHL.ASX) in Apr-25 and continues to scale its patient programs and client base.

Figure 9: VHL's strategic pivot. Entry point 'Wheezo'. For >3yrs built Care Management focused on remote care



Source: VHL

Marjan Mikel, appointed CEO and Executive Director in Nov-19, has >35 years of experience spanning medical devices, pharmaceuticals, SaaS, and remote patient monitoring. Prior to leading VHL, he held senior leadership roles in healthy sleep and respiratory care solutions, most notably overseeing the Australian operations of Healthy Sleep Solutions, which was ultimately acquired by Air Liquide Healthcare.

His track record in commercialising and scaling medtech businesses positioned him as the primary architect behind VHL's strategic pivot, from a single-device respiratory company to a full-service connected care platform. Mikel led the acquisition of Access Telehealth and Orb Health, repositioning VHL as a virtual chronic care enabler embedded in the US VBC ecosystem.

Corporate Rebranding to Vitasora Health (Strategic Reset)

Reflecting its strategic pivot, the company has rebranded to Vitasora Health (ASX: VHL), after shareholder approval at the Apr-25 Extraordinary General Meeting. The rebrand signals its evolution into a comprehensive connected care provider supported by an integrated technology platform and diversified clinical service offering.

To fund execution of this strategy, VHL raised A$4m in growth capital in Mar-25, to be deployed across:

- Scaling sales and account management functions
- Preparing for transformative client contracts and integrations
- Enhancing technology and developing APIs to optimise platform capabilities
- Expanding marketing and engagement activities to build brand and market penetration
- Progressing Orb Health's UPEC product to cross-sell AWV solutions to existing clients

The Result: VHL = Access Telehealth (RPM) + Orb Health (CCM and UPEC platform), with Universal Patient Engagement Centre (UPEC) offering clients AWVs plus an administrative solution.

Technological Offering

Device Agnostic Capabilities: Through this combined platform, VHL delivers a comprehensive, device-agnostic remote care solution:

EMR Integration: Seamless API connectivity to client electronic medical records (EMRs), minimising clinician resistance and streamlining onboarding.

Workflow and Productivity Tools: Features that enhance care team efficiency in managing chronic patient populations.

Billing and Revenue Cycle Management: Integrated coding, claims adjudication, and reconciliation functions to optimise client reimbursement and cash flow.

Virtual Clinic Capability: Offers clients access to VHL's qualified clinical staff for continuous remote monitoring and care coordination.

Predictive Data Analytics: AI-driven tools to track CPT codes, identify diagnoses, and proactively flag gaps in care delivery.

Advantages of the VHL business model?

- Platform filters patient data based on each physician's care plan, flagging only clinically relevant alerts and reducing alert fatigue.
- Personalised thresholds (e.g. higher BP targets for some) ensure escalations match individual patient needs.
- Supports multiple US payer models, including MSSP, Medicare Advantage, CMS-direct, and commercial insurance, accommodating mixed-risk populations.
- Healthcare-first design combines technology with human-led coordination, clinical staff engage patients directly (e.g. phone calls) for compliance.
- Providers can outsource core care functions to VHL's remote team, reducing headcount and admin burden.
- Focus on early intervention and prevention to cut avoidable hospital admissions and support scalable, high-touch care.
- Operates on an opex (vs capex) model with risk-sharing: clients pay only if VHL delivers results.

M&A to Build VHL's Platform & Strategic Partnerships

Access Telehealth Acquisition (Initial Technology Platform)

In Sep-23, VHL acquired Access Managed Services for US$1.25m, providing the platform necessary to transition away from standalone Wheezo device sales to a broader eHealth SaaS model. This marked a key inflection point for the company, establishing a strategic footprint in the US chronic care patient monitoring market.

The acquisition delivered a full-suite RPM solution capable of addressing all major chronic conditions. Since integration, VHL has reworked and optimised the acquired platform in-house, improving client onboarding and the overall user experience. The upgraded software integrates with Wheezo (for respiratory management) and other agnostic medical devices, enabling centralised clinical oversight across a range of chronic disease states.

Ceras IT Platform Partnership (Enhanced Technology Stack)

In Sep-24, VHL entered into a commercial partnership with Boston-based Ceras Health to strengthen its technology platform. Ceras Health, which provides AI-powered patient monitoring and predictive analytics capabilities, became VHL's IT partner for the delivery of remote services to Covenant Health, a Massachusetts-based Catholic health system/IDN.

The initial 3 year fee-for-service contract was valued at US$80 per patient per month (PPPM), of which Ceras receives a US$6-7PPPM clip as a SaaS platform fee for providing its technology and AI-enabled monitoring infrastructure. The agreement automatically renews annually, subject only to termination for material breach, providing contractual durability. Importantly, VHL now leverages the Ceras IT platform across its broader customer base, including the newly acquired Orb Health patients, creating a unified technical backbone for all remote monitoring services. This is an ongoing cost to the company and translates to US$4PPPM at scale (see 'Costs' section page 36).

Within this, Genesys has also been integrated to provide automated quality assurance and quality control of patient calls, enhancing clinical consistency and reducing overhead, refining the patient experience.

Orb Health Acquisition (Other Technology Capabilities and UPEC)

In Jan-25, VHL completed the acquisition of Orb Health, a remote patient monitoring provider, for US$9m. The transaction added annual recurring revenue (ARR) of US$4.2m and delivered cost synergies of approximately US$2.2m. Additionally, Orb Health subscribed for US$0.7m of fully paid ordinary shares as part of the transaction.

Orb Health's acquisition significantly expands VHL's market presence, adding 2,400 patient programs and 11 clients, and unlocking more than A$2m in cross-selling opportunities. Together with VHL's existing business, the combined group is now expected to generate over US$6m in ARR, with total patient programs rising to 3,100 across 29 clients.

Orb Health brings advanced capabilities in Enterprise Virtual Care and Care Management as a Service, further diversifying VHL's platform and supporting its ambition to become a full-spectrum chronic care coordination provider.

Wearable Respiratory Device Study (Emerging Competitive Advantage)

VHL commenced a clinical study for its next-generation wearable respiratory device in Oct-24. The trial involves 30 COPD patients in two cohorts and aims to validate continuous, real-time data transmission to VHL's central platform for nursing team oversight.

Early results from the first cohort have been used to develop advanced visual analytics, tracking patient activity, respiration trends and inhaler usage. The study period concluded Feb-25, with ongoing data analysis ongoing, and a targeted FDA submission in mid-CY25. Regulatory clearance is anticipated in Q1CY26.

The new wearable device is intended to complement and not replace the existing Wheezo offering and will enhance VHL's Connected Care Management program, particularly for transitional care of COPD patients from hospital to the home, billed and reimbursed using CPT codes relating to TCM.

Evolent Care Partners Partnership (First Risk-Share Client Onboarded)

VHL secured a landmark partnership with Evolent Care Partners (NYSE: EVH), a prominent ACO operator with a market cap of approximately A$1.7bn. The evergreen agreement, subject to quarterly review but not requiring a request for proposal or formal tender, reflects ease of market entry and validation of VHL's offering. This marks the first Medicare Shared Savings Plan (MSSP) risk-share agreement for VHL.

Beginning in Apr-25, VHL will deliver care management services for a pilot program covering 1,800 Medicare patients in Hawaii through EVH's MSSP program. The premium Clinic-in-Cloud model is expected to generate revenues of US$100–200PPPM and will assist local healthcare providers in processing reimbursement claims. Beyond the MSSP patients, VHL has since expanded to additional patients managed by the Hawaii Independent Physicians Association.

While EVH currently operates at modest gross margins of 10–20% and remains loss-making at the EBIT and net income level since 2021, the partnership represents a significant opportunity for VHL to make a measurable impact to the performance of EVH. EVH serves over 94,000 Medicare patients across 12 states, positioning VHL to scale meaningfully should pilot outcomes prove successful.

The Physicians Alliance Corporation Partnership (Top Performing ACO)

Following the Evolent partnership, in the Q3FY25 result, VHL announced a strategic partnership with The Physicians Alliance Corporation, a network that oversees two ACOs (TP-ACO and Premier Healthcare). Here, there are over 5,000 physicians and over 17,000 assigned beneficiaries operating in 14 states within the US. Interestingly, their TP-ACO is the 5th most cost-effective ACO in the MSSP and they have established a goal to maintain a quality score in the top 1% of all ACOs, hence providing a level of validation for VHL.

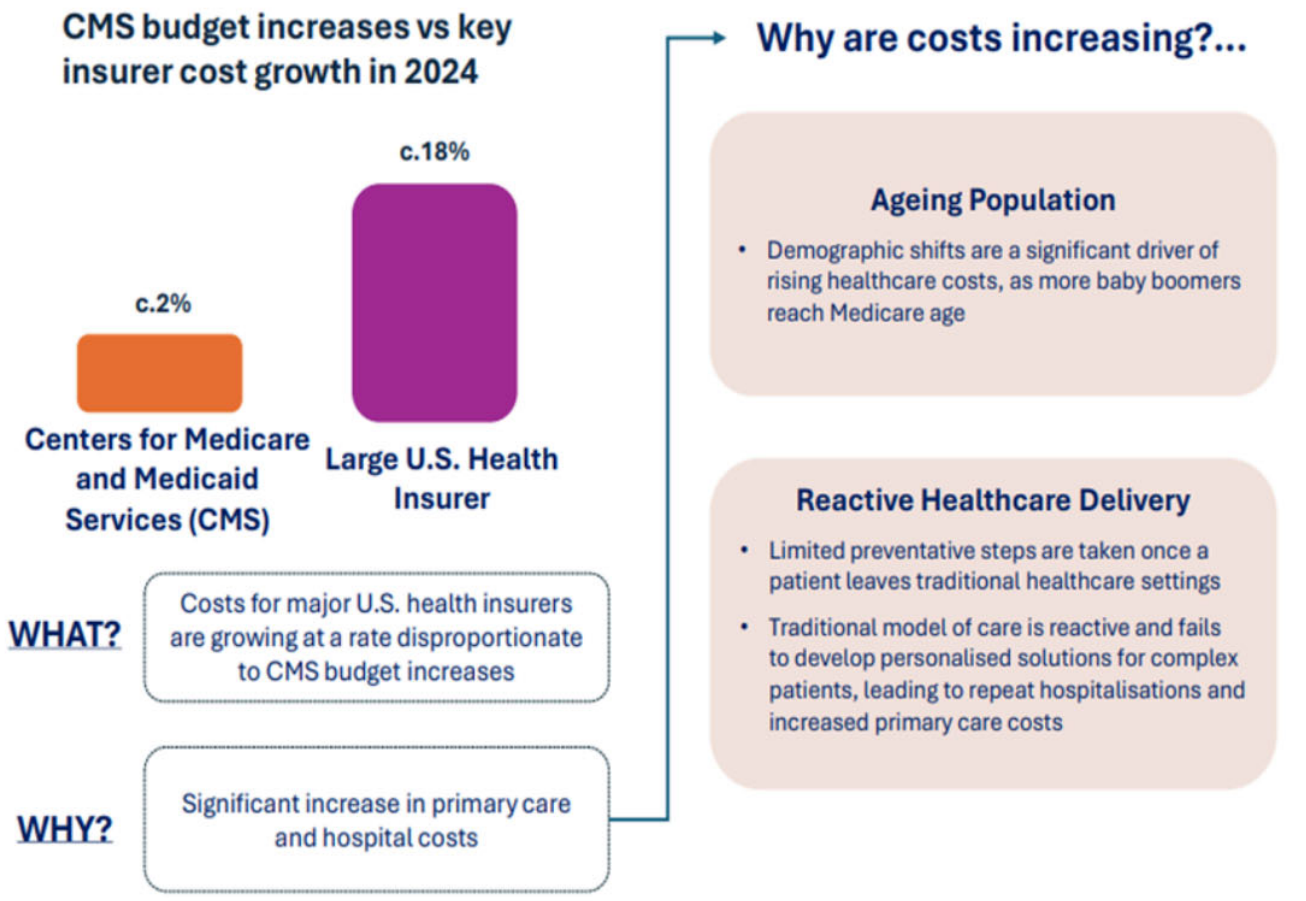
The Problem? Cost Pressures and Poor Clinical Outcomes

Within the US, large health insurers face cost inflation outpacing CMS reimbursement growth by about 18%, an unsustainable trend. Insurers cannot expect CMS budgets to match their rising costs, especially amid government cost-cutting pressures.

Key drivers behind rising US primary care and hospital costs include:

- An ageing population >65 years of age
- Increasing prevalence of chronic disease
- Increasing number of Medicare insured patients
- A reactive healthcare delivery model
- Misalignment between health insurers and health providers
- Labor shortages & provider wage increases

Figure 10: Cost inflation challenges facing the US public health system with worsening patient outcomes



Source: VHL

Industry and Regulatory Tailwinds – VBC & ACO

The US healthcare system is undergoing a structural transition towards value-based care (VBC), strongly driven by regulatory initiatives and reimbursement reforms.

CMS has led this shift, incentivising providers and ACOs to improve outcomes and reduce unnecessary spending through shared savings programs. CMS is pushing for all Medicare patients to be in accountable care relationships by 2030.

In addition, recent updates by the American Medical Association (AMA) to CPT codes have significantly expanded the potential for RPM reimbursement. Changes such as lower minimum data collection thresholds and reduced clinician time requirements will make it easier for providers to qualify for reimbursement. This regulatory support is expected to accelerate RPM adoption across Medicare and Medicaid populations and increase fee-for-service payments by $70–90PPPM.

Other critical regulatory drivers include the Hospital Readmissions Reduction Program (HRRP), which penalises hospitals with excessive 30-day readmission rates. As a remote healthcare solution (RHS) provider, VHL offers hospital systems and health networks an effective means of improving post-discharge monitoring and patient compliance, thereby mitigating the risk of penalties.

Broadly, the continued emphasis on Medicare Advantage expansion, growing Medicaid Managed Care enrolment, and increasing telehealth parity laws across states all represent complementary trends.

The Solution? Value Based Care, the Future of the US Healthcare System?

VHL aims to engage with non-governmental, community-based organisations and private sector entities, including Accountable Care Organisations (ACOs), US health insurers, Independent Physicians Associations (IPAs), Health Systems/Integrated Delivery Networks (IDNs) and Primary Care Providers (PCPs). These stakeholders are integral to the US public health system and are actively seeking value-based care (VBC) alternatives, aligning with the Centers for Medicare and Medicaid Services' (CMS) shift towards this healthcare model.

In VBC, providers receive capitated payments linked to syndicated commercial insurance policies, the amount being determined by the aggregate risk score within the patient population. These risk scores are computed using ICD-10 codes, which represent specific diagnoses, conditions, or symptoms. These codes are used by:

- **Providers:** to document patient diagnoses in the medical record
- **Payers (like Medicare/insurers):** to determine medical necessity and reimbursement
- **Analytics systems:** to risk-stratify patients for care and cost prediction

The Medicare Shared Savings Program (MSSP) is CMS' flagship value-based care initiative, designed to incentivise provider groups, particularly primary care providers (PCPs), to deliver coordinated, high-quality care to Medicare beneficiaries while reducing unnecessary costs.

Capabilities of VHL:

- **Connected Care Management** enables continuous monitoring and support for patients in their home or community settings
- **Digital Platforms** provide centralised dashboards and patient engagement tools for coordinated care management
- **Wearables and Medical Devices** allow real-time tracking of key health metrics such as heart rate and blood glucose
- **Telehealth Platform** facilitates virtual consultations and clinical interactions between patients and trained clinical staff
- **AI-Driven Analytics** support risk stratification, predictive modelling, and delivery of personalised interventions

Benefits of VHL:

- **Improves healthcare accessibility** for underserved or remote populations
- **Enhances patient engagement and adherence** through proactive, personalised care pathways
- **Supports chronic disease management** by reducing hospital admissions and emergency visits
- **Drives better clinical outcomes** while lowering total cost of care through early interventions
- **Provides doctors with actionable data** to enable triage and trigger real-time notification alerts in the event of therapy escalations

Who will pay for the solution?

VHL's primary payers include accountable care organisations (ACOs), US health insurers, independent physician associations (IPAs), health systems / integrated delivery networks (IDNs), and primary care providers (PCPs). These entities contract VHL for outpatient remote patient monitoring (RPM) and care management solutions.

Reimbursement flows across the US healthcare ecosystem, with the CMS acting as the principal funder. Payers typically receive reimbursement either through upfront capitated payments under VBC models, with potential for shared savings, or via fee-for-service payments based on claims submitted at the end of a reporting period.

How is VHL part of the solution?

VHL's value proposition includes the following:

- **Access to Wheezo** - asthma and/or COPD patients can utilise this FDA approved medical device for respiratory conditions, granting exclusive use of the Wheezo (not available to competitors)
- **AI-Driven Patient Identification** - leveraging recent AI capabilities to identify at-risk patients
- **Tailored patient programs** - offering personalised care, which is clinically superior, proven to lead to better outcomes for patients
- **Seamless Onboarding** - easy patient recruitment, consent and onboarding improves patient engagement
- **Local Presence** - hiring local staff creating community-based solutions which oversee patient monitoring
- **Simplified Claims and Billing** - developed a streamlined process for healthcare organisation clients and onboarding
- **Clinic-in-Cloud** - comprehensive care management services reducing workload of clients
- **High CMS/Medicare Alignment** - integration with CMS billing codes and risk-share models, supports ACO and Medicare provider participation

Figure 11: Indicative comparison between VHL versus competitors

Feature	VHL	Competitors
FDA-cleared respiratory RPM device	Wheezo (unique)	Most competitors do not offer this
Integrated RPM + CCM	Clinic in Cloud, care coordinators	Matches HealthSnap, CareSimple, Cadence
Medicare/ACO focus	Yes	High overlap, but strong value proposition
Risk-share + FFS model	Both revenue models supported	Flexibility not offered by all competitors
Scalable SaaS + device integration	Full-stack solution	Competitive with top players

Source: VHL

VHL has indicated the following outcomes achieved under its current in-service patient base:

Figure 12: VHL currently takes care of 6,500 patient programs

Key Outcome	Percentage
Reduction in re-hospitalisations	56%
Reduction in length of hospital stay	42%
Reduction in emergency room visits	47%
Improvement in medication compliance	91%

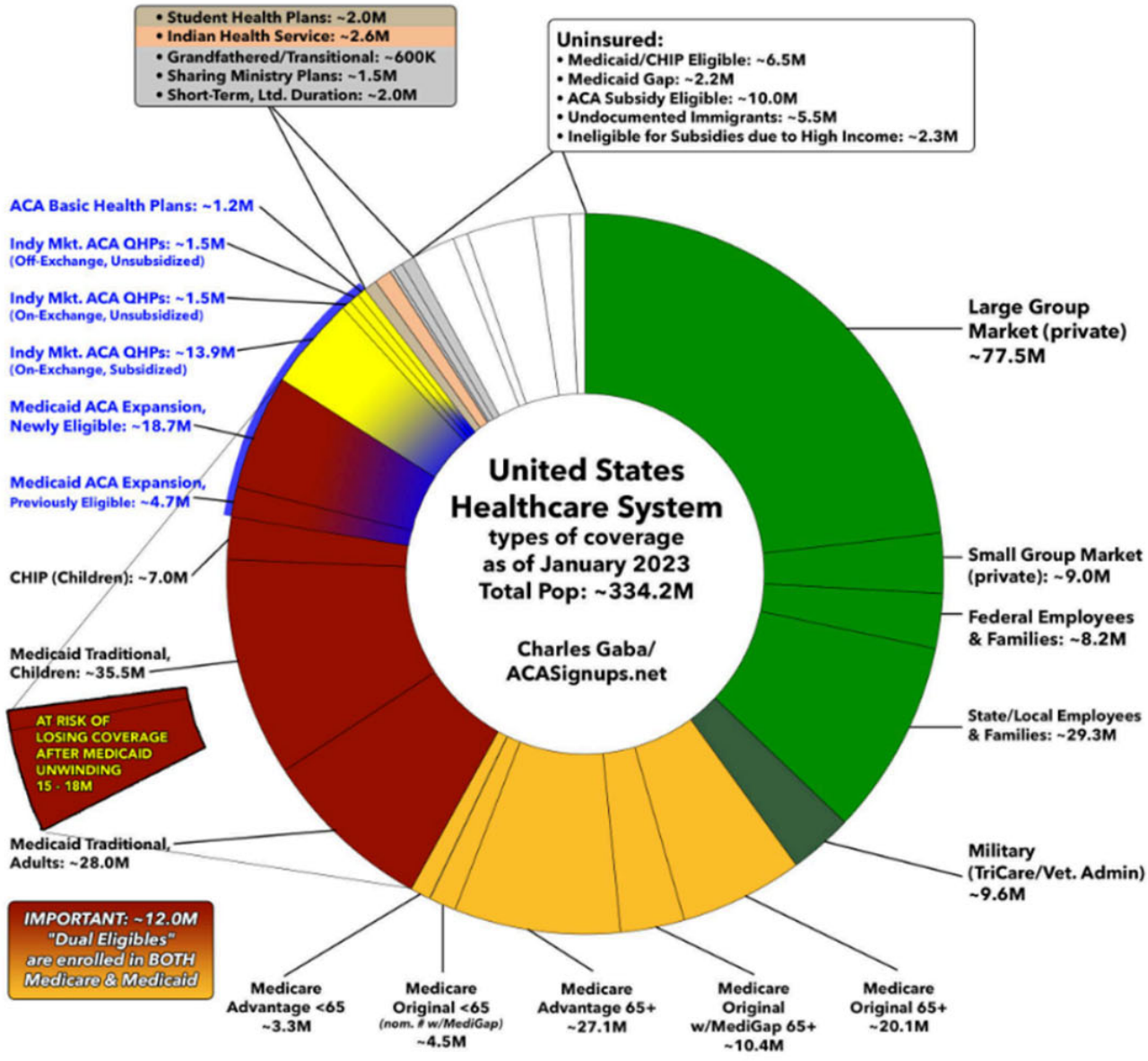
Source: VHL

US Health Insurance & Spending Basics

Background – USA Health System [more detail Appendix A]

The US healthcare system is the world's largest, with **US$4.5tn in spending (17.3% of GDP)** in 2022, and projected to reach **20% of GDP by 2032.**

Figure 13: USA Healthcare Insurance Coverage – in detail (Green – Commercial; Yellow – Medicare; Red – Medicaid)

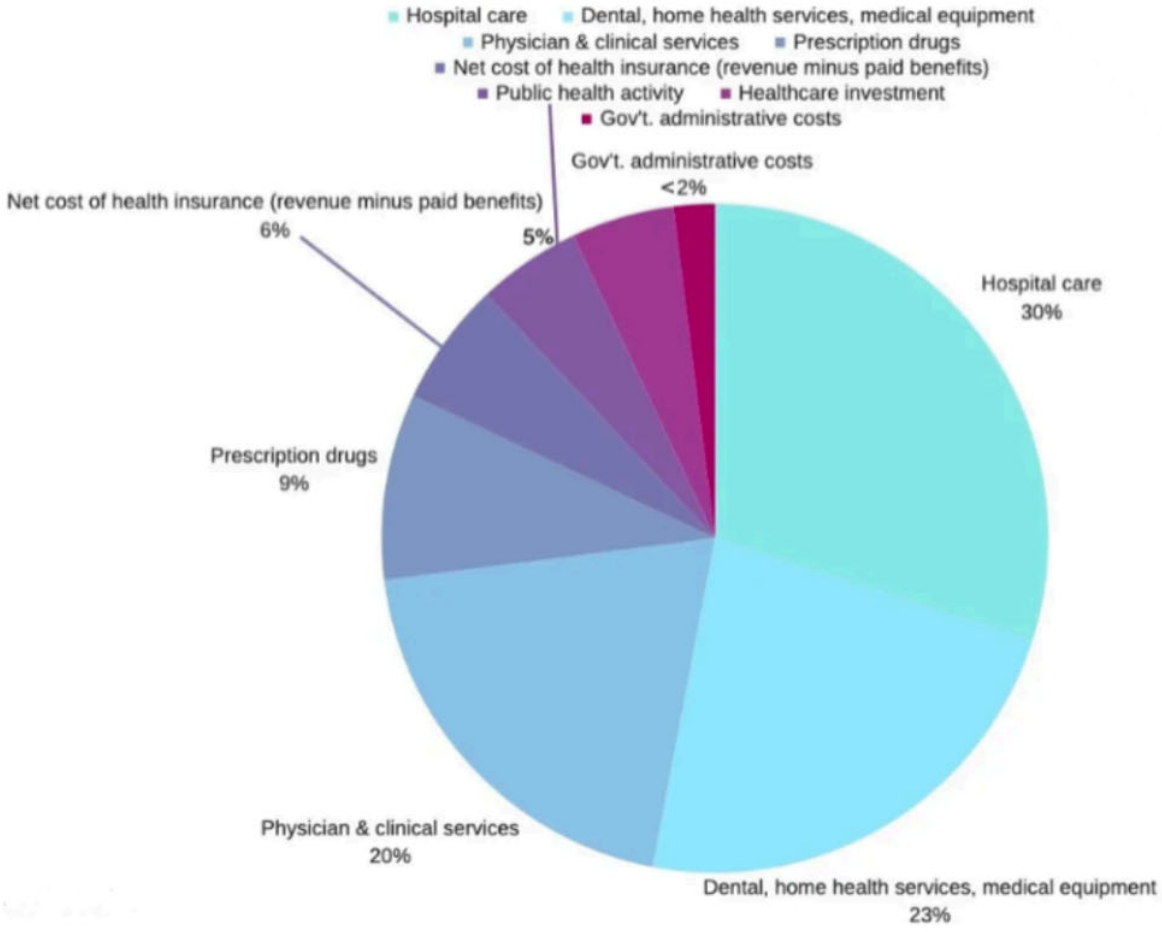


Source: ACA

Components:

- **Medicare**: Federal funded for over +65 yr olds. Covers **~68m** people (~60m aged 65+, ~8m disabled). Includes Parts A (hospital), B (outpatient), C (Medicare Advantage), and D (drugs).
- **Medicaid**: Co-funded Federal/State run covering the socially vulnerable. Covers **~93m** low-income individuals, including Children's Health Insurance Program (CHIP).
- **Private / Commercial insurance**: Covered **~182m** including employer-sponsored (self-insured) plans and Affordable Care Act (ACA) marketplace coverage-remains (24m people enrolled in ACA marketplace plans for 2025).

Figure 14: US Health Spending in 2022 was US$4.5tn



Source: CMS

Spending breakdown: Hospitals (30% of total Health system costs), physician services, drugs, and administrative overhead.

Growth outlook: Healthcare spending growth at 5.6% pa to outpace US GDP estimated at 4.3% pa through 2032, driven by aging population and chronic disease.

Structural Megatrends within the US Healthcare System

Accelerating growth of Medicare and Medicaid patients: The aging population and expanded eligibility have led to increased enrolment in Medicare (>65 years of age) and Medicaid (low income) programs. This growth presents both challenges and opportunities for healthcare providers to manage resources effectively while ensuring quality care.

Commercial insurance syndication and capitated payment models: There is a growing trend towards syndicating commercial insurance policies and adopting capitated payment models, where providers receive a set amount per patient regardless of services rendered. This approach encourages cost-effective care and aligns with the principles of VBC.

Pandemic paradigm shift toward remote health and telehealth: The COVID-19 pandemic has accelerated the adoption of telehealth services, highlighting the importance of remote healthcare solutions (RHS) in maintaining continuity of care and expanding access, particularly in underserved areas. This trend is likely to continue irrespective of the political administration.

Market Opportunity – TAM

Total Addressable Market – projected to reach US$30bn

Around 150m Americans live with one or more chronic conditions, including an estimated 50m affected by respiratory diseases such as asthma and COPD. These respiratory conditions alone impose a US$134bn burden on the US healthcare system, with each COPD-related hospitalisation costing an average of US$28,000.

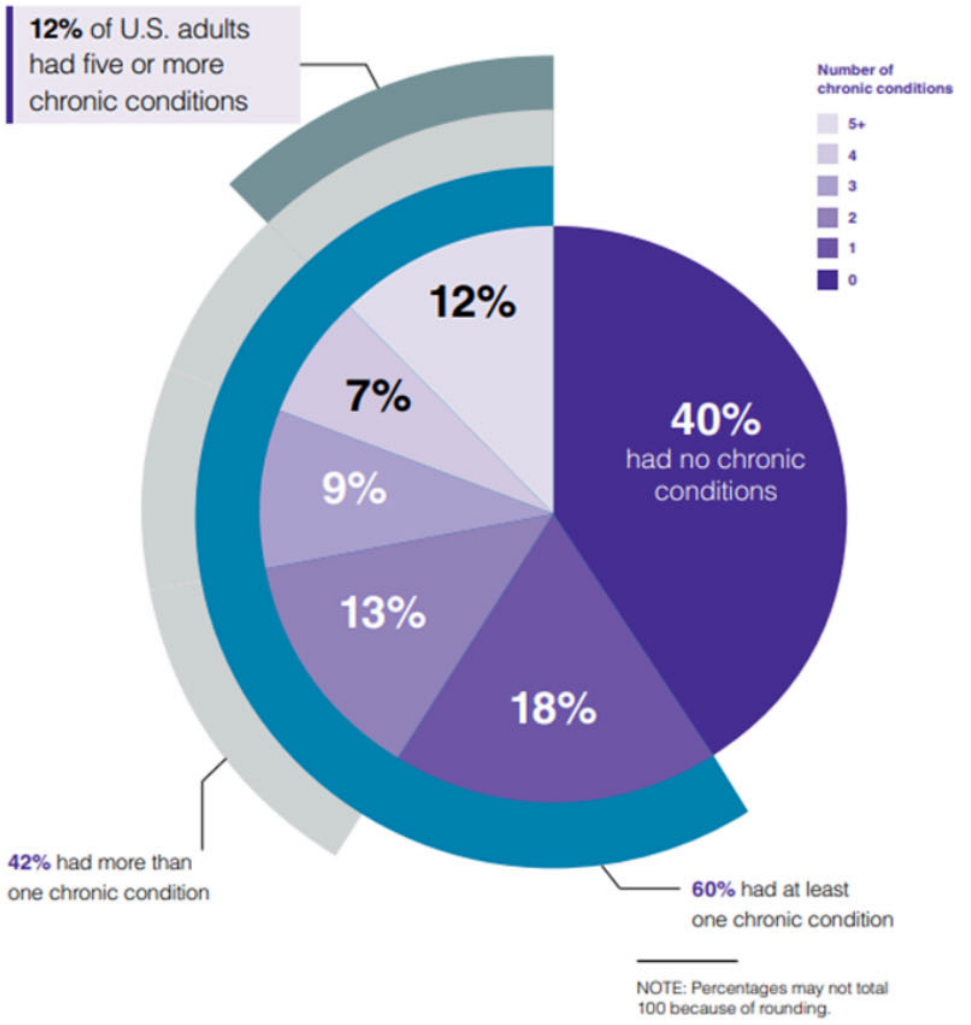
VHL's market focus aligns with the US RPM market, which is projected to reach ~US$30bn by 2030, growing at a CAGR of 11.2%. From ~US$18bn in 2025, the market is expected to almost double within 5 years, underpinned by shifting reimbursement models and growing demand for chronic disease management.

Chronic disease and ageing population to drive growth

VHL's target market is particularly supported by demographic and epidemiological trends, which indicate a substantial and growing demand for personalised, technology-enabled care solutions. This includes:

- >60% of US adult citizens live with 1+ chronic condition
- >60% of US citizens aged >55 live with 2+ chronic conditions
- US citizens aged >65 will double in the next 25 years

Figure 15: % of US adult citizens with number of chronic conditions



Source: Rand Research

Significant ‘at-risk’ population suited to RPM solutions

A large portion of the chronically ill population remains poorly controlled. Approximately 140m patients with hypertension, diabetes, congestive heart failure and respiratory disease are classified as ‘at risk’ due to suboptimal disease control. These patients represent a significant opportunity for VHL to deliver value through post-acute care, ongoing monitoring, and early intervention. Further, a 2022 Harvard study noted that nearly 50m Americans were already using some form of RPM device, a figure expected to rise as technology and reimbursement frameworks continue to mature.

Figure 16: Key Chronic Conditions in the US: Prevalence and Uncontrolled Rates

Condition	No. of Patients (US)	% Uncontrolled	No. Uncontrolled (US)	Other Comments
Hypertension	120M	78%	93M	Major prevalence
Diabetes	28M	60%	16.8M	High rate uncontrolled
Congestive Heart Disease	7M	65%	4.2M	Significant management gap
Respiratory (COPD/Asthma)	43M	60%	25.8M	High burden, poor control

Source: VHL

Some 162m Americans are now covered by value-based care (VBC) where health plans and providers to share responsibility (“risk”) for health outcome costs and quality; examples include Accountable Care (ACO’s), capitation & bundled payments. US CMS aims to transition all traditional Medicare beneficiaries to ACO’s by 2030. Patient data is key in care compliance, clinical decisions & payment. Remote patient monitoring (RPM) is integral, particularly in chronic care & reduction unplanned admissions/waste.

Figure 17: Estimate of Total US Patients in risk (ie. ACO) or VBC plans by Health Insurance provider, last 20yrs (millions)

Year	Medicare ACO Patients	Medicare Advantage Patients	Medicaid Patients in VBC	Commercial VBC Patients	Total Patients in Risk/Value-Based Models
2005	0.0	3.5	1.0	5	9.5
2010	0.0	10.5	3.5	15	29.0
2015	23.5	17.5	12.5	40	93.5
2020	11.0	24.0	23.4	60	118.4
2025	12.0	30.0	42.0	78	162.0

Source: CMS, AJMC, KFF, AJMC, LAN. Notes: MA Plan Growth: Medicare Advantage plans have grown from ~1,200 in 2005 to ~4,000 in 2025, driven by policy incentives (e.g., Medicare Modernization Act of 2003) and consumer demand for supplemental benefits.

Figure 18: Organisations and plans that fall into the "risk-based care" category

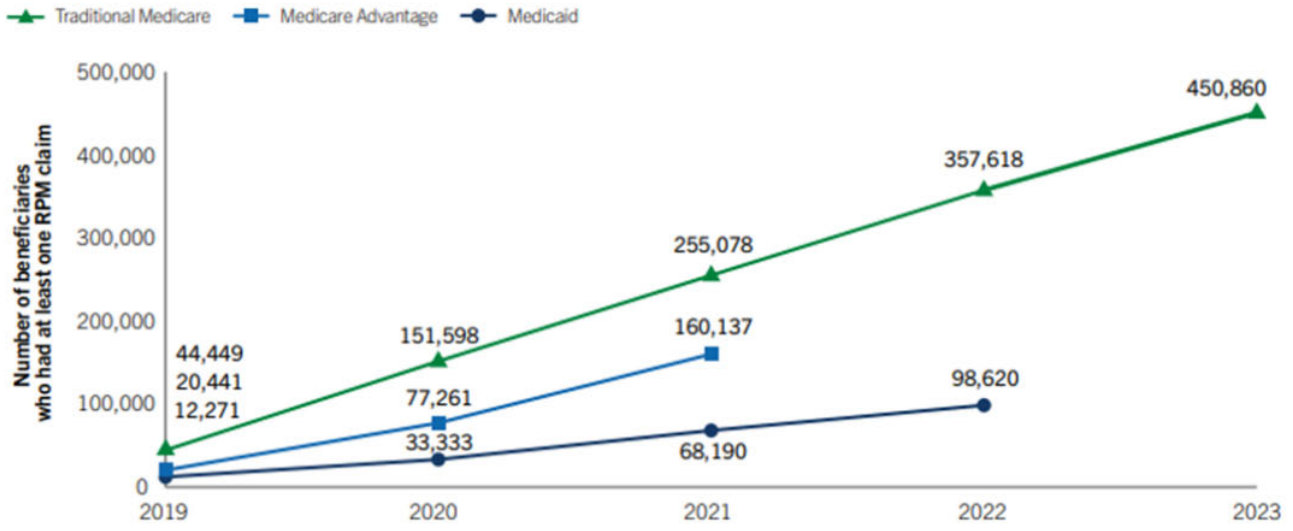
Organization/Plan Type	*Example Entities/Plans*	*Risk Model Type*
Medicare Advantage	UnitedHealthcare, Humana, Aetna	Full capitation
ACOs (Medicare/Commercial)	MSSP, ACO REACH, Next Gen, CCA	Shared savings/losses
Medicaid MCOs	Centene, Molina, Anthem	Full capitation
High-Needs ACOs	HarmonyCares, Bloom Healthcare	Two-sided risk
Commercial Risk-Based Plans	Cigna, Blue Cross, Aetna (employer)	Bundled, pop-based, cap
Provider Enablement Orgs	agilon health, Privia, Carelon	Supports provider risk
Bundled Payment Programs	BPCI, CJR	Episode-based risk
Population-Based Payment	Various APMs	Full/partial population

Source: CMS, Paragon

Key Trends from the Peterson Centre on Healthcare RPM Report TAM

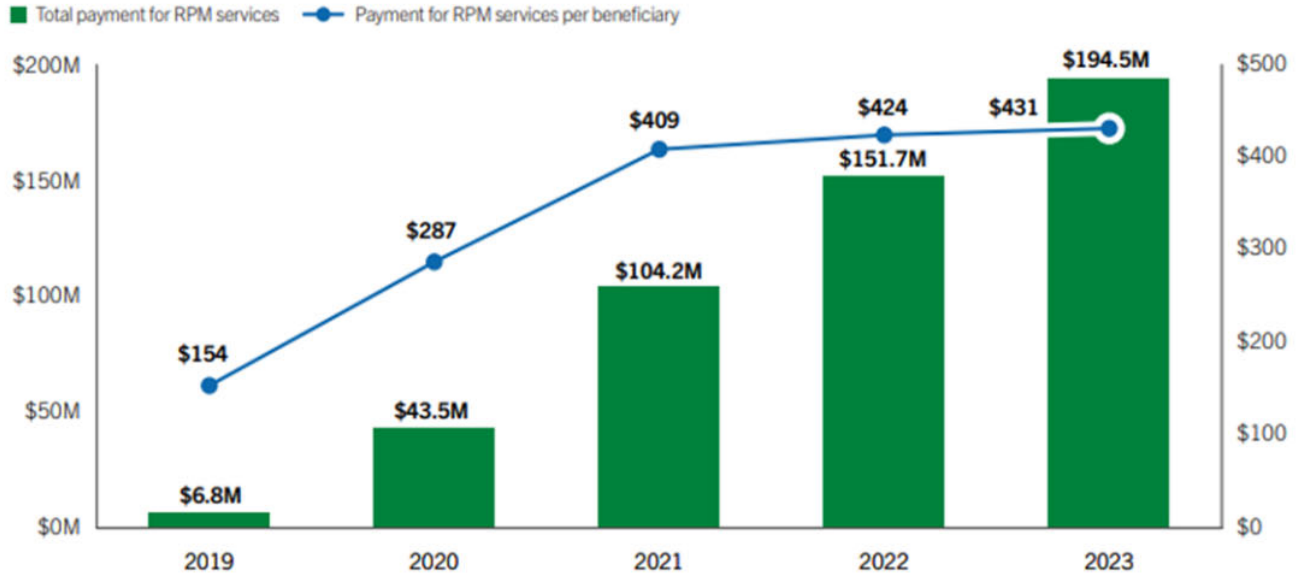
- **RPM adoption among Medicare beneficiaries is expanding rapidly**, with Traditional Medicare usage rising from 44,500 patients in 2019 to 451,000 in 2023. Medicare Advantage usage grew 14-fold between 2019 and 2022.
- **RPM program durations are increasing**, with average usage rising from 1.7 to 5.2 months over the same period. Notably, 22% of patients are now monitored for over nine months.
- **Hypertension is the leading condition managed via RPM**, accounting for 57% of all cases and averaging the longest monitoring duration at 6.6 months.
- **RPM spending is accelerating**, with Traditional Medicare spending reaching US$194.5m on RPM and US$10.4m on RTM in 2023.
- **Per-patient RPM spending has nearly tripled**, increasing from US$154 in 2019 to US$431 in 2023, reflecting broader adoption and extended engagement across Medicare and Medicaid programs.

Figure 19: RPM is growing substantially across all user types but is most pronounced with traditional Medicare over 10x



Source: Peterson Centre on Healthcare

Figure 20: RPM spending with traditional Medicare is rapidly growing



Source: Peterson Centre on Healthcare

Key Growth Drivers

VHL's growth strategy is underpinned by favourable macro reimbursement trends, ongoing expansion of its sales pipeline and patient programs, and regulatory changes that are lowering barriers to adoption for RPM services. Together, these drivers reinforce the company's positioning as a scalable, technology-enabled chronic care management provider.

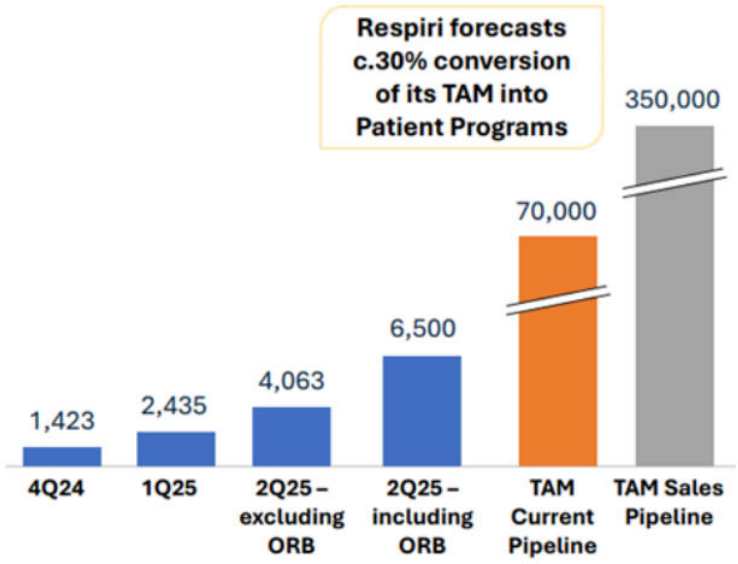
Expanding Client Base and Growing Patient Programs

VHL's addressable client base includes a range of healthcare payers — from health insurers and ACOs to Health Systems/IDNs, PCPs and IPAs. Notably, ACOs have emerged as a critical target given their preference for RPM solutions that accommodate "risk-share" revenue models. These models, which are increasingly supported by CMS reimbursement frameworks, offer lower per member per month (PMPM) subscription fees but meaningful upside through shared savings when RPM drives improved patient outcomes and reduces costly hospitalisations.

For other payers not seeking risk-sharing arrangements, VHL's traditional SaaS-based RPM model remains compelling, with standard PPPM rates supporting recurring revenue.

Patient growth has been driven by both organic and inorganic channels. Over FY24, VHL's organic programs grew ~13x from 314 to 4,063 patient programs. In addition, the acquisition of Orb Health added 2,400 programs and 11 clients, lifting total programs to approximately 6,500. Adjusted for churn after the Mar-25 quarter, total patient programs amounted to 6,398, although it still represents a material increase in contracted patient programs and reflects growing sales momentum.

Figure 21: Sales Pipeline, Current Pipeline and growing number of Patient Programs



Source: VHL

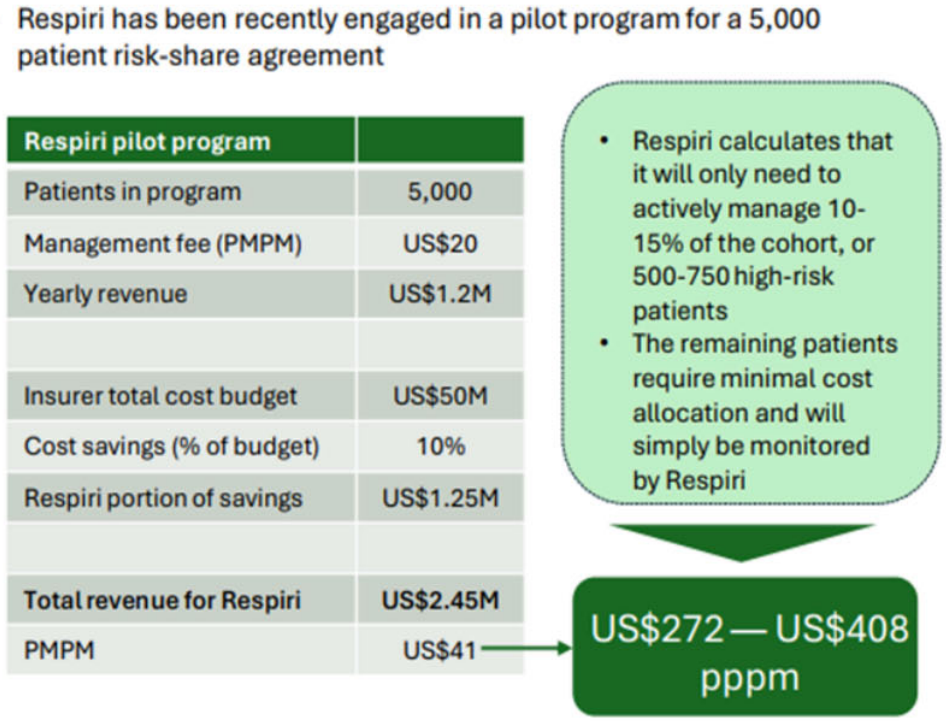
Favourable CMS Policies Driving Risk-Share Model Uptake

The US healthcare system is undergoing a structural shift towards accountable care, supported by the widespread adoption of capitated payments and risk-share models. Under CMS' strategic objective, all traditional Medicare beneficiaries are expected to be aligned with a care provider accountable for the total cost and quality of care by 2030. This policy direction underpins the expansion of ACOs and similar VBC frameworks.

To facilitate this transition, CMS provides capitated payments to healthcare insurers, which serve as upfront budgets based on patient risk scores. These funds allow payers to offer comprehensive care, including preventive and remote monitoring services, which are often excluded from traditional fee-for-service models due to constrained doctor resources. Insurers are increasingly seeking to align incentives across the care continuum by 'pushing down' risk-sharing mechanisms to provider organisations such as ACOs and IPAs. This ensures that both insurers and providers are financially motivated to improve patient outcomes and reduce unnecessary costs, subsequently sharing the realised savings.

While risk-sharing arrangements currently represent a relatively small proportion of overall healthcare contracting, insurers are highly focused on expanding this model and making it the standard across VBC programs. For VHL, this shift is highly supportive. The company's RPM and care management solutions are well positioned to help providers meet care quality benchmarks, reduce avoidable hospitalisations, and unlock shared savings under these new reimbursement paradigms. As a result, risk-share models are becoming increasingly attractive for both healthcare payers and VHL alike.

Figure 22: Indicative cost savings and upside risk in VHL's risk-share revenue model



Source: VHL

CPT Code Changes to Improve Reimbursement Outlook

In a further regulatory tailwind, the American Medical Association (AMA) has proposed updates to Current Procedural Terminology (CPT) codes covering RPM services, aimed at increasing patient access and easing provider compliance. These changes are expected to be endorsed by CMS during 2025 and come into effect from Jan-26.

Figure 23: Proposed changes to the billable CPT codes

CPT Code	Current Requirement	Proposed Change
99454	16 days of data in a rolling 30-day period	Reduced to 2 days
99457	20+ mins of interactive clinical communication per month	Reduced to 11–20 mins
99458	Additional billable time for every 20 mins	Reduced to every 10 mins

Source: AMA

VHL estimates that the proposed CPT code changes could expand the proportion of patients eligible for RPM reimbursement from ~60% to 90%, unlocking ~US$108 in additional annual revenue per patient. By lowering the clinical engagement and data transmission thresholds, these revisions reduce the administrative burden and enable staff to manage more patients concurrently, effectively increasing operational leverage. As a result, per patient per month (PPPM) revenue may rise from ~US$70–90 to an ~US$140–180. However, this uplift may be partially offset by pricing adjustments as reimbursement requirements become easier to meet.

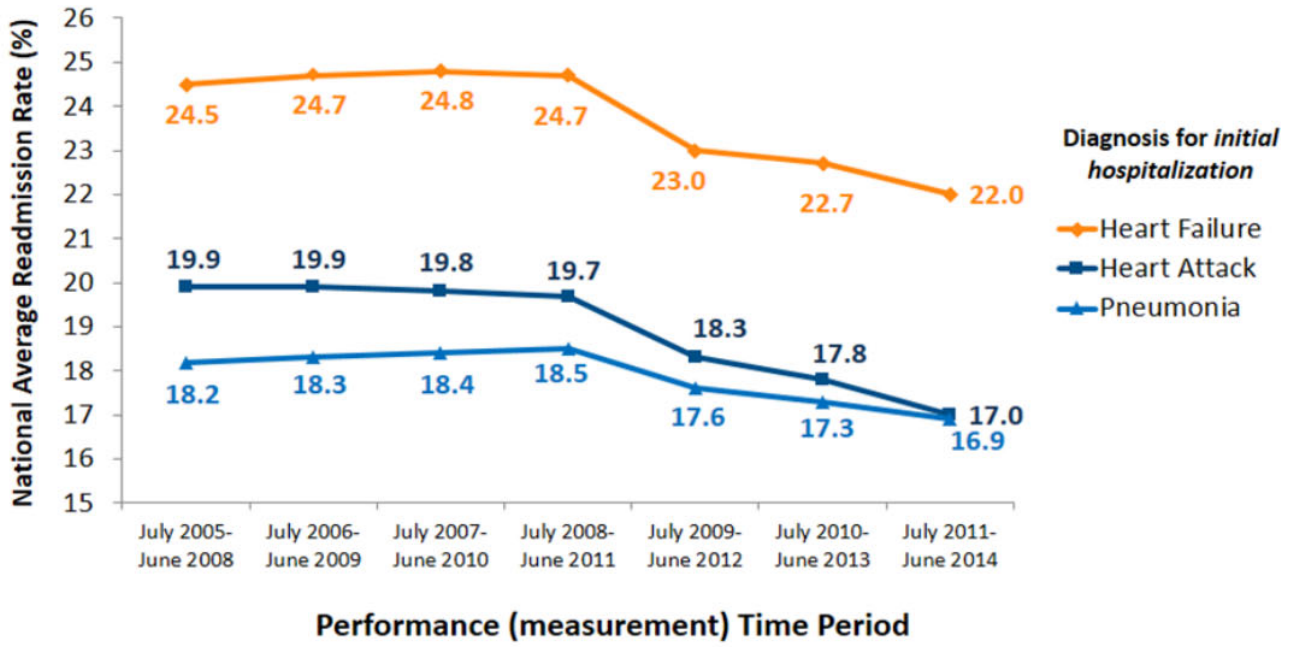
Penalisation under the Hospital Readmissions Reduction Program

VHL also benefits from policies designed to penalise high readmission rates. Introduced under the Affordable Care Act in 2010, the Hospital Readmission Reduction Program (HRRP) applies payment reductions of up to 3% to hospitals with excessive 30-day readmissions for specific conditions, including:

- Acute myocardial infarction
- Chronic obstructive pulmonary disease (COPD)
- Heart failure
- Pneumonia
- Coronary artery bypass graft
- Total hip/knee arthroplasty

Since inception, readmission rates have steadily declined, driven by stronger incentives for hospitals to improve discharge planning and outpatient care coordination. VHL's RPM and care management programs are directly aligned with this need, offering hospitals a mechanism to monitor patients post-discharge and reduce penalties.

Figure 24: Medicare readmission rates started to fall in 2012 under the HRRP when CMS began measuring performance



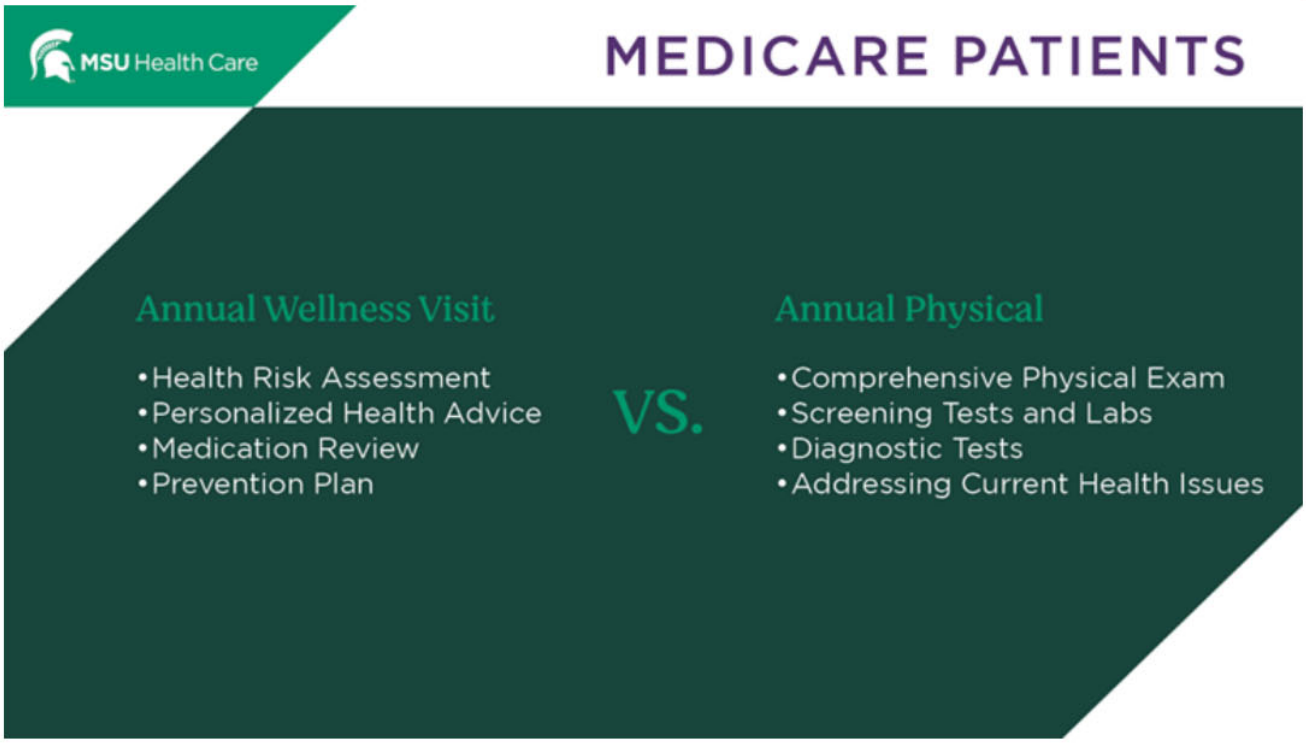
Source: Kaiser Family Foundation

Cross-Selling and Product Expansion

With its integrated platform and growing client base, VHL is increasingly positioned to expand revenue per customer through cross-selling and product extensions. In particular, the rollout of its UPEC capabilities in Q4CY25, including services like AWVs, present a material upsell opportunity within existing RPM contracts. As clients seek to maximise CMS risk adjustment revenues and meet care quality benchmarks, VHL can leverage its established provider relationships and technology stack to broaden service adoption. This not only enhances client retention but also drives higher recurring revenue through expanded service penetration.

Finally, it permits an accurate ICD-10 and HCC analysis to ensure full reimbursement for more complex patient cases. This is important, as for example, if the patient has been identified to have multiple chronic conditions, then the CPT codes can be billed under both the higher CCM payments as well as RPM. This translates to higher margins, with increased revenue per unit of time and improved clinical outcomes.

Figure 25: AWVs are the optimal starting place to recommend RPM programs and prompt patients for risk assessments



Source: Michigan State University Health Care

RPM Market Components

The US RPM market is divided into four key segments. VHL is primarily positioned within the platform, services, and device provider segment, the largest and fastest-growing category, which encompasses integrated care delivery, clinical monitoring, and connected hardware. The remaining three segments focus on software setup, infrastructure, and integration services. These are largely ancillary to VHL's operations and have limited direct relevance to its core full-stack RPM and care management model.

Figure 26: Segmentation of the market landscape - VHL is a RHS provider

Source: MarketsAndMarkets Research

Market Barriers & Drivers for Vitasora

Barriers:

- **Clinical Monitoring Burden** – Continuous RPM generates vast volumes of data, creating alert fatigue and placing operational strain on clinical teams.
- **Patient Readiness & Privacy** – Older, chronically ill patients are often less tech-literate and more cautious about data sharing, slowing adoption.
- **Data Integration Challenges** – Seamlessly merging third-party RPM data into EMR systems while maintaining clinical usability and HIPAA compliance remains complex.
- **Regulatory Complexity** – Constantly evolving healthcare regulations require ongoing compliance oversight and flexibility in product design.
- **Trust & Data Security** – High-profile breaches and concerns around data misuse can undermine confidence in RPM platforms.

Drivers:

- **Ageing & Chronically Ill Population** – The US has a growing base of high-risk patients who require scalable, tech-enabled chronic care solutions.
- **Proven Cost & Clinical Benefits** – RPM has demonstrated reductions in hospitalisations and improvements in outcomes, making it attractive to payers and providers.
- **Technology Acceptance** – Increased familiarity with medical devices, telehealth, and consumer wearables post-COVID is accelerating RPM adoption.
- **Supportive Reimbursement Environment** – CMS-backed changes to CPT codes and the shift toward value-based care (e.g. ACO/IPA models) align directly with VHL's offering.
- **Interoperability & Flexibility** – VHL's platform is device-agnostic and EMR-compatible via API, providing clients with adaptable and scalable infrastructure beyond its proprietary Wheezo device.

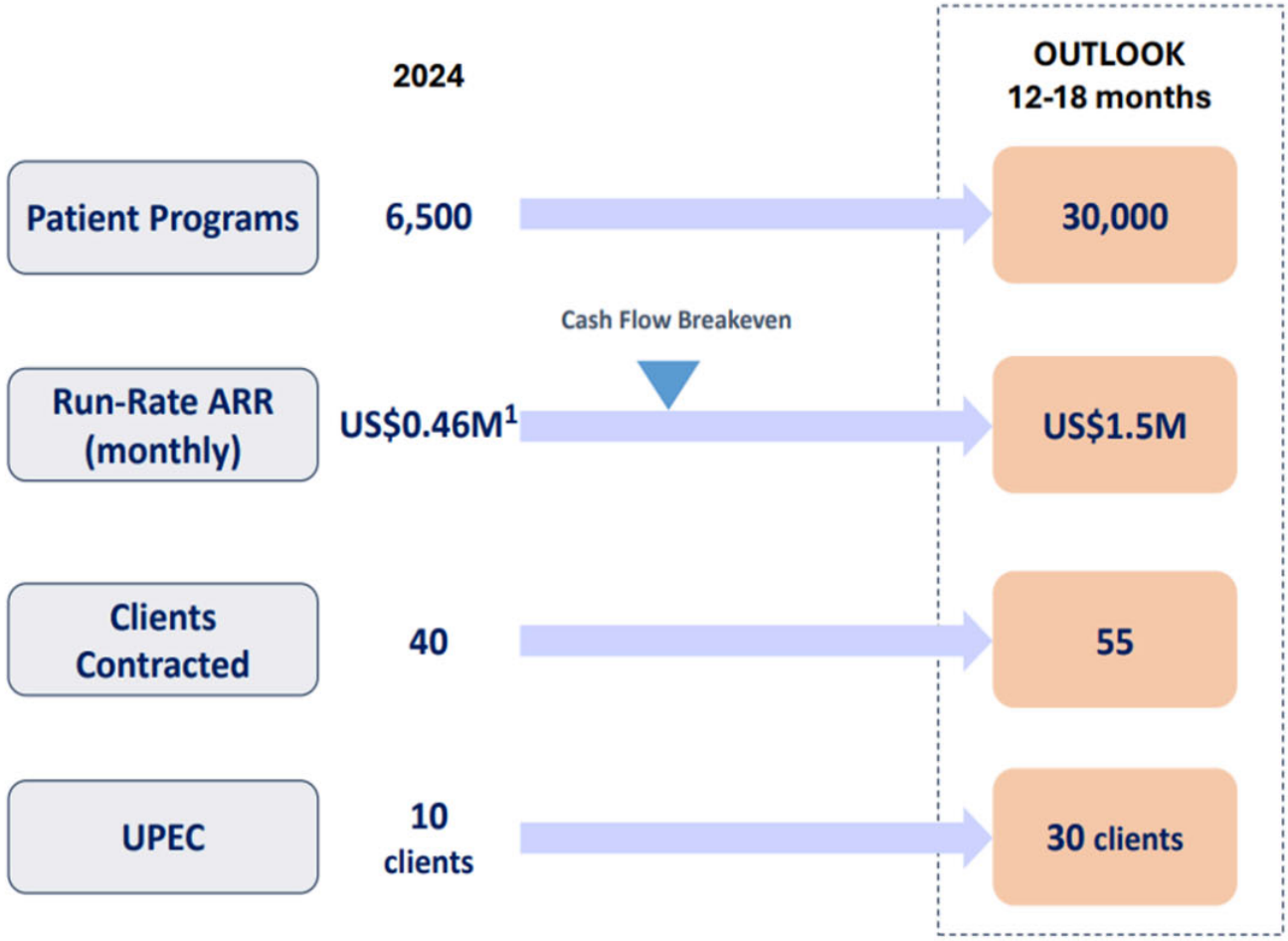
Pipeline & Outlook

Advanced Client Discussions (Continued Acceleration of Patient Programs)

VHL has indicated near-term target opportunities include:

- **Evolent Care Partners –** Potential upgrade upon successful completion of the pilot program
- **New major ACO –** 17,000 Medicare patients in 14 states
- **NYSE listed Insurer –** 1m holders and 74,000 high risk members
- **California based ACO –** Over 500,000 Medicare patients and high risk contracts
- **Ohio based HCO –** With 25 facilities servicing approximately 20,000 Medicare patients
- **A state-based insurer –** With approximately 200,000 Medicare patients
- **California based hospital –** Involving TCM with about 14,000 discharges pa
- **Florida based HCO –** Including 150,000 Medicare patients

Figure 27: Management's expected outlook for the next 12-18 months as of CY2024 end



Source: VHL

Competition

Background – Competitive landscape

VHL operates in a rapidly evolving US remote care market, where RHS have become central to Medicare-aligned providers. While many competitors offer RPM tools, few deliver fully integrated models that combine clinical services, technology, and reimbursement optimisation. VHL stands out with its proprietary respiratory device (Wheezo), flexible fee-for-service and risk-share models, and seamless CMS billing integration. Further, its platform supports the full spectrum of CPT-billable services, including RPM, CCM, PCM, RTM, and TCM, alongside administrative functions such as patient prompting and billing management, positioning it as a comprehensive solution provider.

Key Competitors

Figure 28: Indicative competitive positioning chart

Company	Offering	Notes
HealthSnap	Full-stack RPM + CCM + billing automation for Medicare providers	Closest direct competitor; similar client base and CPT model
AMC Health	CMS-aligned RPM + telehealth, including care escalation	Direct overlap in Medicare CPT billing; stronger in telehealth
Teladoc Health	Comprehensive virtual care, including RPM	Comprehensive virtual care + RPM, Medicare-aligned
Biofourmis	AI-powered RPM + predictive analytics for chronic conditions	Strong clinical focus; known for heart failure monitoring; limited Medicare penetration
Cadence	AI-led RPM with in-house clinical team, focused on HTN & CHF	Primarily commercial/employer market; not Medicare-aligned
100Plus	Rapid-deploy RPM targeting older adults, device-focused	Medicare-oriented; limited care coordination infrastructure
CareSimple	EMR-integrated RPM with turnkey platform for PCPs	Competes with VHL's Clinic-in-Cloud model; less focus on respiratory
Omada Health	Digital chronic condition platform (diabetes, HTN, behavioural health)	Focuses on engagement over RPM; employer/payer centric
Vivify Health (Optum)	RPM for large health systems; payer-integrated via UnitedHealth	Targets IDNs; less relevant to VHL's ACO/PCP market
Prevounce	RPM, CCM, and preventive services platform	Customisable platform, Medicare billing, proprietary devices

Source: MST

Competitive Positioning

Axes:

X axis: Medicare Alignment

- **Left:** Low alignment with Medicare (focus on commercial/employer markets)
- **Right:** High alignment with Medicare (optimised for CMS billing and ACOs)

Y axis: Clinical Integration

- **Bottom:** Low clinical integration (primarily technology platforms)
- **Top:** High clinical integration (comprehensive care coordination and services)

Positioning:

Top-Right Quadrant (High Medicare Alignment & High Clinical Integration):

- **VHL:** Offers a proprietary respiratory device (Wheezo), integrated care coordination, and value-based pricing models deeply aligned with CMS billing codes.
- **AMC Health:** CMS-aligned RPM and telehealth provider, offering care escalation and clinical support with a focus on Medicare and Medicaid populations.
- **HealthSnap:** Provides full-stack RPM and CCM solutions with billing automation tailored for Medicare providers.

- **Teladoc Health**: Comprehensive virtual care services, including RPM, with strong Medicare Advantage alignment and integrated care coordination.

Top-Left Quadrant (Low Medicare Alignment & High Clinical Integration):

- **Biofourmis**: AI-powered RPM and digital therapeutics platform with predictive insights; strong clinical pathways, but limited Medicare-specific optimisation.
- **Cadence:** Focuses on AI-led RPM with in-house clinical teams, primarily serving commercial and employer markets.

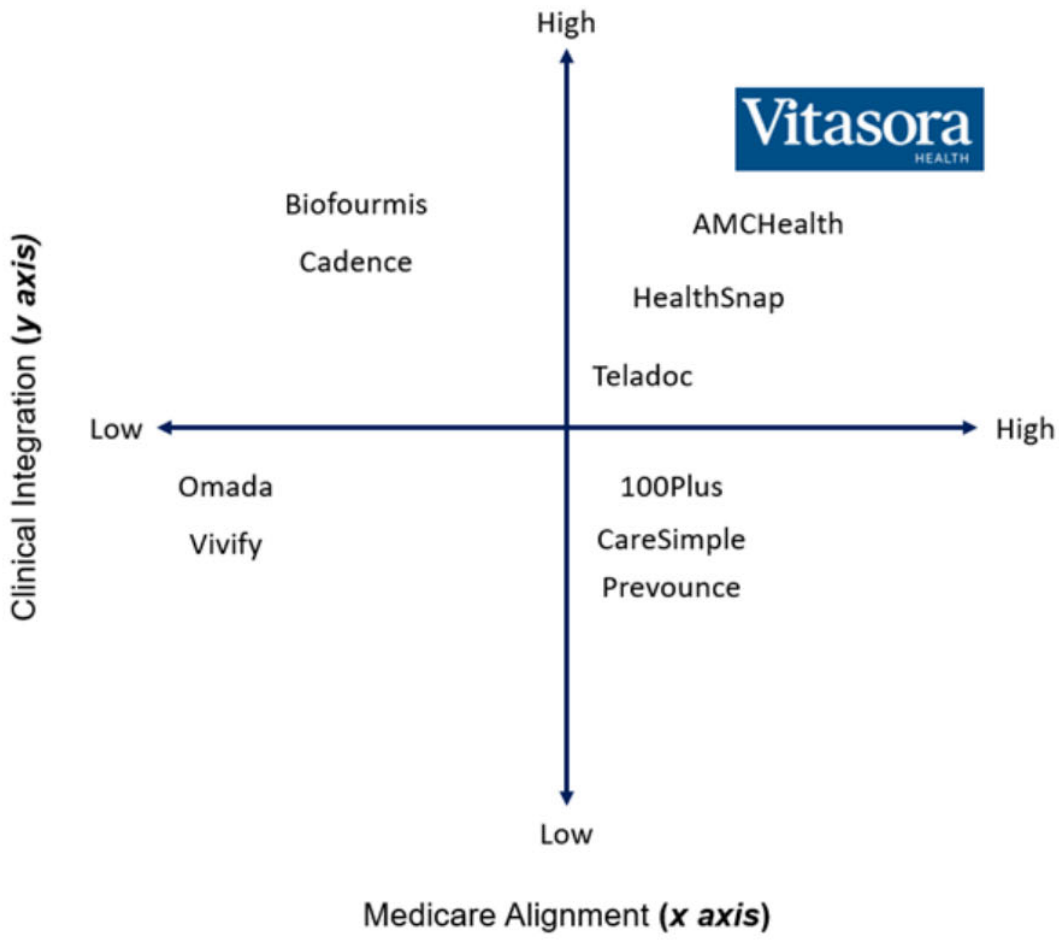
Bottom-Right Quadrant (High Medicare Alignment & Low Clinical Integration):

- **100Plus:** Offers rapid-deploy RPM targeting older adults with a device-focused approach, limited in care coordination infrastructure.
- **CareSimple:** Provides EMR-integrated RPM platforms for PCPs, competing with VHL's Clinic-in-Cloud model but with less emphasis on respiratory care.
- **Prevounce**: Customisable RPM and CCM solutions with Medicare billing support; offers proprietary devices but with less emphasis on integrated clinical services

Bottom-Left Quadrant (Low Medicare Alignment & Low Clinical Integration):

- **Omada Health:** Focus on digital chronic condition platforms (e.g., diabetes, hypertension) with a focus on engagement over RPM, targeting employer and payer markets.
- **Vivify Health (Optum):** Delivers RPM solutions for large health systems, integrated via UnitedHealth, with less relevance to VHL's target market

Figure 29: Indicative competitive positioning chart



Source: MSTe

Financials

Profit & Loss

The MST VHL model references both the (1) Sales Pipeline (addressable TAM) and; (2) Current Pipeline (patient TAM) to arrive at; (3) Patient Programs (revenue generating patients), as laid out by the company. In addition, MST also accounts for the differing revenue models for related pricing.

MST notes that VHL obtains revenue on a per patient per month (PPPM) basis, operating similarly to a SaaS subscription model. Only RPM operations within the US are included throughout the forecast period.

Revenue forecasts and key assumptions

MST assumes VHL will not be eligible for any further R&D tax grants as they begin commercialisation of their RPM rollout.

The drivers of revenue include:

- **Sales Pipeline –** represents the number of patients attributed to the **potential** overall client base of healthcare providers. This currently has 350,000 patients available within the client patient population. We apply a conservative discount to the growth rate projected by company guidance, noting it is a function of both the speed and size of clients onboarded.
- **Current Pipeline –** represents the number of patients attributed to the **actual** client base of healthcare providers. This currently has 70,000 patients within its contracted client patent population. We assume that the delta between the two pipelines remains the same, with the current pipeline remaining 20% the size of the sales pipeline.
- **Patient Programs –** represents the number of **revenue generating patients** within the current client base of healthcare providers. Here, we use the 30% conversion rate of the current pipeline as per company guidance and again apply a conservative discount adjusting for time. The 30% is derived from VHL's historical staff outreach success rate (where verbal consent is obtained, patient receives medical devices and then are trained on using medical devices).
- **Patient Split –** represents the relative distribution of the Patient Programs amongst the different revenue models outlined by VHL.
- **Billing Codes –** VHL offers various remote care services which are tied to different CPT codes. Note they are not mutually exclusive and MST currently does not consider the proposed changes by the AMA, which may further upwardly revise the PPPM fees.

Other key assumptions:

- Initially, existing patients are almost exclusively assigned to the fee-for-service revenue model. Once the AMA proposed CPT changes come into effect Jan-26 and increasingly large clients are onboarded, we view these as catalysts and model a terminal patient split as following:
  - Fee-for-Service: 50%
  - Fee-for-Service (Clinic-in-Cloud): 20%
  - Risk-share: 30%
- **Pricing:** Charged at the midpoint of the provided ranges for PPPM, fee-for-service and fee-for-service (Clinic-in-Cloud) revenue models generate no additional upside. Risk-share revenue model is the capitated payment model which adjusts for the additional upside risk that VHL shares with the payers. The additional upside generated from the transaction is applied to the midpoint of the PPPM range and factors in an engagement rate for the high at-risk patients provided by management. VHL has reported an engagement rate of 8-15% and we use the upper end of this range to arrive at an aggregate figure of ~US$167PPPM.
- **Churn Rate:** 20% of Patient Programs occurring on an ongoing basis.
- **Industry Consolidation:** We assume the industry becomes consolidated in 2030 in line with the CMS goal of having all Medicare beneficiaries being in accountable care. This means post-2030 the growth rate of the sales pipeline slows significantly.
- **Market Penetration:** Forecast patient programs represent approximately 0.1% of the ~150m Americans living with chronic conditions.
- **AUD/USD:** 0.65. Note that a stronger USD results in an upgrade to AUD earnings, vice versa.

Simple Unit Economics: Under the traditional fee-for-service model (before AMA changes), remote care earns US$1/minute

Revenue recognition

Revenue per patient is applied to the number of Patient Programs from the prior period, as the growth in Patient Programs reflects an annualised run-rate versus actual revenue. This approach is purposefully conservative and reflects the lag in revenue recognition due to onboarding and service delivery timelines. A similar methodology is applied to COGS, aligning costs with the corresponding patient cohort from the previous period.

MST also notes that the timeline from signing a client to fully onboarding their respective patients and then receiving revenue, is approximately 9 months. The discounts we apply to the growth and conversion rates (detailed above) pertain to the expected time delays as they relate to onboarding and revenue recognition.

Base Scenario: MSTe minimal penetration of VHL's RPM solution, solely in the US.

Upside Scenario: Should VHL demonstrate superior RPM delivery and exceed the pace of client acquisition relative to our conservative assumptions, MSTe anticipates an accelerated revenue trajectory driven by faster growth in patient programs and improved pipeline conversion. A more rapid adoption of VHL's risk-share model across the US healthcare system would further amplify this upside. Notably, VHL's CEO has indicated that the company may be eligible to receive up to 25% of total cost savings generated for payers under risk-share arrangements, which would materially enhance margins under this model.

Figure 30: VHL P&L

VHL P&L (A$m)	FY23	FY24	FY25E	FY26E	FY27E
RPM / Subscription / Software Fees	0.1	0.5	5.0	16.5	30.0
Total sales revenue	**0.1**	**0.5**	**5.0**	**16.5**	**30.0**
Other income/expense (incl R&D Grant)	0.6	0.6	-0.1	-0.4	-0.8
Total group revenue	**0.7**	**1.0**	**4.9**	**16.1**	**29.2**
R&D costs	-0.4	-0.1	-0.1	-0.2	-0.2
Corporate and administrative costs	-5.2	-6.9	-7.6	-8.3	-9.2
Share based payment expense	-0.3	-0.5	-0.6	-0.6	-0.6
Other expenses	-0.3	-0.5	-0.5	-0.5	-0.6
Total operating expenses	-6.3	-8.0	-8.8	-9.6	-10.5
EBITDA	**-5.7**	**-7.0**	**-6.6**	**-1.8**	**4.7**
D&A	-0.1	-0.1	-0.1	-0.3	-0.6
EBIT	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**4.1**
Net interest	0.0	-0.1	0.0	0.0	0.0
PBT	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**4.1**
Tax	0.0	0.0	0.0	0.0	-1.2
NPAT	**-5.8**	**-7.1**	**-6.6**	**-2.1**	**2.8**
Revenue growth		57%	375%	227%	81%
Opex growth		28%	9%	9%	9%
EBITDA growth		-23%	6%	72%	-357%
R&D % of revenue	57%	13%	3%	1%	1%
Corporate and administrative costs % of revenue	57%	13%	3%	1%	1%
Share based payment expense % of revenue	795%	665%	154%	52%	31%
Other expenses % of revenue	955%	776%	178%	60%	36%
EBITDA margin	-865%	-677%	-133%	-11%	16%
EBIT margin	-876%	-683%	-135%	-13%	14%
NPAT margin	-878%	-689%	-135%	-13%	10%

Source: VHL, MSTe

Costs

COGS/R&D

- COGS include medical device (US$60/one-time per patient), set-up costs (US$2/one-time per patient), SaaS fees (US$4PPPM), cellular fees (US$1PPPM) and clinical staff costs (US$24/hr). We assume that clinical staff spends 1hr per month per patient (6hrs across a 6 month period).
- R&D costs we assume will only grow at 5% to support the conclusion of the wearable respiratory device study and any ongoing R&D for the platform and/or new medical devices.

OPEX (ex R&D)

- MST OPEX (ex-R&D) to grow at 5%, except corporate and administrative costs which grows at 10%, accounting for the overhead costs which are required to sustain VHL's extensive push toward commercialisation and adoption of its connected care management solution at scale.

Balance Sheet

Capital management

- **Cash –** VHL had a cash balance of A$2.2m at end of Mar-25. VHL is also due a further A$1.6m cash (second tranche) to be received Jun-25, as part of the completed Mar-25 capital raise.
- **Debt –** VHL has negligible debt of A$0.2m (ongoing short-term credit). MSTe does not assume any significant debt going forward.
- **Capital raises –** MST has not modelled a capital raise. However, the cash position would infer that a capital raise is likely in the future.
- **Share issuance –** MST has note modelled any further share issuance. However, should a capital raise occur, then further share issuance is likely.
- **Exercise of options –** VHL has issued share options dated from FY25 to FY28 with varying strike prices. MST notes that at the current share price, none of these options would be exercised. Although, in Jun-25 at a strike price of A$0.07cps, there are almost 80m options which would yield almost A$5m.

Figure 31: VHL Balance Sheet

VHL Balance Sheet (A$m)	FY23	FY24	FY25E	FY26E	FY27E
Cash	0.1	0.8	-1.4	-12.5	-20.3
Trade & other receivables	0.0	0.3	6.1	14.8	25.1
Inventories	2.6	2.8	2.1	2.3	2.6
Other	0.2	0.3	0.4	0.4	0.4
Total current assets	**3.0**	**4.0**	**7.3**	**5.1**	**7.7**
Property, plant & equipment	0.0	0.0	0.1	0.2	0.4
Intangible assets	0.0	0.1	0.1	0.3	0.5
Other	0.0	0.0	0.0	0.2	0.3
Total non-current assets	**0.2**	**2.2**	**2.3**	**2.7**	**3.2**
Total assets	**3.2**	**6.2**	**9.5**	**7.8**	**11.0**
Trade & other payables	1.7	1.9	2.4	2.6	2.8
Current tax liabilities	0.0	0.0	0.0	0.0	0.0
Interest-bearing liabilities	0.3	1.2	0.0	0.0	0.0
Other	0.1	0.1	0.0	0.0	0.0
Total current liabilities	**2.2**	**3.4**	**2.7**	**2.9**	**3.1**
Interest-bearing liabilities	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0
Total non-current liabilities	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**
Total liabilities	**2.4**	**3.6**	**2.8**	**3.0**	**3.2**
Net assets	**0.8**	**2.6**	**6.8**	**4.8**	**7.8**
Contributed equity	132.1	140.5	151.2	151.2	151.2
Reserves	6.8	3.7	2.8	2.8	2.8
Retained earnings	-138.1	-141.6	-147.2	-149.2	-146.3
Total equity	**0.8**	**2.6**	**6.8**	**4.8**	**7.8**

Source: VHL, MSTe

Cash Flow & Capital Adequacy

- MST has used 275 days for Debtors Days; the long duration for cash conversion reflects time from monitoring to result and payment. MSTe VHL achieves positive net operating CF in FY29. FCF also turns positive in FY30, supporting the future cash balance of the company.
- Other operating cash flows include government grants, R&D tax credit claims and the net change in working capital.

On MSTe VHL has <2 qtrs of cash runway. MST does not model any further capital raisings at this time, however, considering the current cash position a capital raise may be likely.

~A$2.6m cash burn from the most recent Mar-25 quarterly reflects the increased costs from the acquisition of Orb Health before cost synergies. Cash burn may trend lower for the ensuring quarters.

Figure 32: VHL Cash Flow Statement

VHL Cash Flow Statement (A$m)	FY23	FY24	FY25E	FY26E	FY27E
Operating cash flows					
Receipts from customers / other	0.1	0.1	4.6	16.5	30.0
Payments to suppliers & employees	-5.2	-7.4	-12.2	-17.9	-24.5
Income tax paid	0.0	0.0	0.0	0.0	-1.2
Other operating cash flows	0.6	0.6	-3.8	-9.1	-11.0
Net operating cash flows	**-4.5**	**-6.6**	**-11.4**	**-10.5**	**-6.8**
Investing cash flows					
Capex (R&D and PP&E)	0.0	0.0	-0.1	-0.6	-1.0
Payment for investment in controlled entity	0.0	-1.9	0.0	0.0	0.0
Other investing cash flows	0.0	0.0	0.0	0.0	0.0
Net investing cash flows	**0.0**	**-1.9**	**-0.1**	**-0.6**	**-1.0**
Financing cash flows					
Proceeds from issues of shares	3.3	8.2	9.3	0.0	0.0
Proceeds from borrowings	0.2	0.9	0.2	0.0	0.0
Payment of dividends	0.0	0.0	0.0	0.0	0.0
Other financing cash flows	0.0	0.0	0.0	0.0	0.0
Net financing cash flows	**3.5**	**9.1**	**9.3**	**0.0**	**0.0**
Net cash flow	**-1.1**	**0.6**	**-2.2**	**-11.1**	**-7.8**
Closing cash balance	0.1	0.8	-1.4	-12.5	-20.3
Free cash flow	**-4.5**	**-6.6**	**-11.5**	**-11.1**	**-7.8**

Source: VHL, MSTe

Valuation

MST values VHL at A$0.12cps using a discounted cash flow (DCF) on future earnings (current share price A$0.04cps) with a forecast period out to FY35. Our fully diluted share count does not currently include any options considering the current share price, however, it does factor in the expected dilution arising from the Orb Health acquisition and the A$4m Placement offer.

Key variables from our DCF valuation are shown below:

Figure 33: Key DCF Assumptions - forecast period out to FY35

NPV	**A$187m**
Net cash	**A$1m**
Enterprise value	**A$186m**
Diluted shares (includes Orb Health acquisition and A$4m Placement)	**1,600m**
Value / share	**A$0.12**
CAPM	
Risk-free rate	**4.5%**
Equity beta	**1.0**
Equity risk premium	**8.5%**
Cost of equity	**13.0%**
Equity	**100%**
Weighted average cost of capital	**13.0%**

Source: MSTe

Comparable Peers - in brief

Cadence Care was last valued at US$1 billion in Dec-21, reflecting investor confidence in chronic condition management platforms within the RPM and CCM sectors. While market conditions have since normalised post-COVID, this valuation remains a notable benchmark for emerging players with clinical integration and a strong payer-provider interface.

A relevant precedent, though not a direct RPM/CCM comparator, is Livongo, acquired by Teladoc Health in 2020 for US$18.5bn, representing a forward revenue multiple of 8–12x. Livongo demonstrated solid growth (115% YoY in 2019) and gross margins (~70–75%) through its recurring PMPM (per member per month) model. The strategic rationale behind the acquisition was to integrate Livongo's chronic care platform with Teladoc's virtual care offering, enabling significant cross-sell synergies and operational scale.

Post-COVID market rationalisation has brought valuations down from peak levels. Now mature digital health platforms such asTeladoc trade at approximately 4–6x forward revenue, while private digital health transactions continue to support valuations of 20–30x EBITDA for high-quality, profitable assets.

Risks

Risks to Vitasora

Adoption & Execution Risks – Even with regulatory approvals, widespread adoption by healthcare providers, insurers, and patients is not guaranteed. Physician resistance, integration challenges with ACOs, IPAs, and existing EMRs, as well as slow reimbursement approvals, could delay adoption. Effective sales, marketing, and strategic partnerships are critical for success.

Financial & Funding Risks – VHL relies on external funding to support product development, regulatory approvals, and commercialisation. VHL's financial sustainability depends on securing additional funding, maintaining revenue from existing contracts and ensuring timely Medicare and insurer reimbursements. If cash inflows do not materialise or further investment is not secured, operations may be at risk. Shareholder dilution and debt refinancing could also present challenges. The reliance on fee-for-service revenue exposes the business to potential policy shifts. Risk-share model contracts, which require cost-reduction targets, add an element of financial variability.

Competition & Newer Technology – VHL operates in a competitive digital health and remote monitoring market, with established players such as Philips, GE Healthcare, and Medtronic offering alternative, non-Medicare-focused solutions. The rapid advancement of new technologies such as AI-driven diagnostics, biosensors, and wearable health devices poses a risk of undermining VHL if it fails to innovate and differentiate its offerings. The consolidation of healthcare providers and insurers could alter contract dynamics and limit market opportunities.

Cybersecurity & Data Privacy Risks – VHL's platform collects and transmits sensitive patient health data, making it a target for cybersecurity threats, hacking, and data breaches. Compliance with HIPAA in the US and other health data regulations is essential to avoid legal liabilities, reputational damage, and financial penalties. Additionally, interoperability with various EMRs is required for seamless data exchange. This may include additional costs for cybersecurity upgrades in compliance.

Regulatory & Reimbursement Risks – As a medical device and digital health company, VHL must navigate complex regulatory approvals. Delays or rejections could impact commercialisation efforts. Additionally, changes in Medicare, Medicaid, and private insurance reimbursement policies for RPM and CCM may affect revenue generation. Timing and state-level variability in reimbursement structures further complicates expansion.

Geographic Concentration Risk – VHL's primary focus is the US market, making it vulnerable to regulatory changes, shifts in reimbursement policies, and healthcare policy uncertainty. Expanding overseas could mitigate this risk but would require additional regulatory approvals and market adaptation.

Supply Chain & Manufacturing Risks – VHL depends on third-party suppliers for medical device components and contract manufacturing partners. Risks include supply chain disruptions, component shortages, geopolitical instability, and cost inflation. Quality control issues could lead to product recalls, regulatory scrutiny, and reputational damage.

Legal & Liability Risks – Potential risks include product liability claims, patent disputes, data privacy lawsuits, and contractual obligations. The risk-share model introduces additional liability concerns, as VHL shares downside risk in the event of efficacy shortfalls or external health-related events (e.g., severe flu seasons) impacting patient outcomes.

Technology, AI & Platform Risks – Ensuring the reliability and security of VHL's AI-driven patient onboarding and monitoring processes is crucial. Errors in AI outputs could lead to dissatisfaction, regulatory concerns, and reputational damage. Advances in AI-driven healthcare solutions may also increase competition, requiring ongoing investment in differentiation and innovation.

Macroeconomic & External Risks – Rising healthcare costs, inflation, and broader economic downturns could impact healthcare funding, reimbursement rates, and the financial viability of VBC programs. Market volatility and changes in government funding priorities may further impact growth prospects.

Medical Device Development Risks – The development of new medical technologies involves scientific uncertainty, lengthy regulatory approval processes, and potential commercialisation delays. There is no guarantee of success in obtaining regulatory approvals or achieving projected revenue targets.

Other Barriers to Adoption of RPM:

- Barriers such as language differences, limited internet access, low digital health literacy, and geographic isolation hinder engagement with RPM, especially in rural and low-income communities where broadband is scarce and digital skills are lower
- Other demographic disparities in chronic disease management persist, with rural hospitals 33.5% less likely to adopt RPM and millions of homes lacking the necessary connectivity

Potential impacts of tariffs

1. Short-Term Impact on Investment Decisions

Newly introduced tariffs on Chinese-manufactured medical equipment may prompt US HCOs to reassess short-term capital allocations. Potential partners such as EVP could delay commercial agreements as they navigate procurement impacts. This may modestly slow client onboarding in the near term.

2. Offset by Cost-Containment Priorities

At the same time, rising input costs may incentivise HCOs to adopt Remote Patient Monitoring (RPM) and virtual care solutions as part of broader cost-reduction strategies. VHL's platform, which supports hospital avoidance and CMS-aligned reimbursement, is well positioned to benefit from this shift.

3. Strong Policy Tailwinds

Albeit Health Secretary Robert F. Kennedy Jr. has reaffirmed federal support for AI and telehealth as enablers of access and system reform. His emphasis on virtual care, especially for underserved and rural populations, aligns directly with VHL's Connected Care model and delivery approach.

4. Minimal Supply Chain Exposure

Tariffs have limited operational impact on VHL. The company holds over two years' inventory of its proprietary Wheezo device in the US, ensuring continued commercial readiness and deployment capability.

5. Absorbed Cost Increases

For impacted ancillary devices (e.g., cellular BP monitors), estimated cost increases of ~US$30 per unit will be absorbed by VHL. This equates to approximately 13 days' worth of fee-for-service reimbursement and will not affect client pricing.

6. Uninterrupted Execution

All current and planned deployments, including those with ACOs, remain on schedule. Client pricing, device provisioning, and commercial rollout plans are unchanged.

7. Enhanced Strategic Positioning

With growing policy emphasis on domestic medical supply resilience and rehoming US manufacturing, VHL's US-based inventory model and device-agnostic architecture support long-term strategic alignment and supply continuity.

Opportunities

Pathway to Cash Flow Breakeven

VHL has publicly targeted achieving cash flow breakeven within the next 12 months, which we view as a key inflection point for any technology-enabled healthcare business. Management has reaffirmed this objective, which, if achieved, should materially reduce the need for further shareholder dilution while also providing enhanced financial and operational flexibility. This would allow the company to reinvest internally to drive growth or, over time, consider capital management initiatives to return value to shareholders. Note, that MST does not forecast VHL to be FCF until FY30.

Expanding the Client and Patient Pipeline

Securing new clients directly expands both VHL's Sales and Current Pipelines, which in turn drives growth in total Patient Programs. Each new client relationship brings the potential to onboard large pools of patients into VHL's chronic care management programs, significantly increasing revenue potential. The company's ability to systematically expand market share and penetrate large healthcare networks will be key to driving scale and valuation upside. Notably, VHL's CEO referenced an existing patient list of a client containing ~89,000 patients as a meaningful near-term opportunity for pipeline expansion through its "go-hunting" model.

Upselling Existing Clients and Expanding Revenue Streams

As client relationships mature, VHL aims to migrate customers toward its higher-value revenue models, specifically Clinic-in-Cloud and risk-share arrangements. These models offer premium PPPM rates and stronger recurring revenue potential. Upselling will depend on demonstrating clear clinical and financial value to providers. In parallel, VHL is exploring new revenue streams including monetisation opportunities from Orb Health's UPEC, particularly AWVs, and the potential sale of de-identified metadata. Collectively, these initiatives are designed to increase average revenue per patient and diversify income sources.

Product Innovation and Cross-Selling Opportunities

Ongoing product development and feature enhancements represent another important catalyst. Continuous platform upgrades will help VHL meet the evolving needs of clients and patients while maintaining its competitive edge. The company's product roadmap is expected to drive both customer retention and new client acquisition. In addition, cross-selling opportunities, such as offering Orb Health's UPEC product across the existing client base, could unlock incremental revenue streams end of CY25 and beyond.

Favourable Regulatory and Industry Tailwinds

Finally, ongoing regulatory and industry shifts in the US are expected to continue supporting VHL's growth. As CMS advances its value-based care agenda, including risk-share models and capitated payment frameworks, demand for RPM and chronic care management solutions is likely to increase. Upcoming CPT code changes (likely effective from Jan-26) and existing schemes such as the HRRP are creating strong financial incentives for providers to adopt VHL's platform. These macro trends should provide structural support for VHL's risk-share revenue model and accelerate client onboarding.

Management

Execution credibility

In our view, VHL is uniquely positioned to adapt and capitalise upon the strategic realignment in the RHS industry with emphasis upon the US chronic disease market. We would expect future key appointments as market share and regulatory landscape evolves, underpinned by efficient cost control. Note all management business functions can be completed remotely.

Profile of Board - in brief

Nicholas Smedley, Non-Executive Chair

- **Tenure:** Appointed in Oct-19.
- **Previous Experience:** >15 years of experience as an investment banker at UBS and KPMG having worked on international M&A transactions. Key areas of expertise include M&A, Debt structuring, corporate governance and innovation.

Jonathan Adams, Non-Executive Director

- **Tenure:** Appointed in Feb-25.
- **Previous Experience:** >15 years of experience in private equity and venture capital, specialising in direct investments, co-investments, and fund investments. Former accountant at PwC and formed Chairman of the Board for Orb Health. Extensive expertise in deal structuring, financial analysis, and corporate governance.

Profile of Senior Management - in brief

Marjan Mikel, CEO and Executive Director

- **Tenure:** Appointed in Nov-19.
- **Previous Experience:** >35 years of experience across a range of healthcare companies with a focus on RPM, medical devices, business SaaS and pharmaceuticals. Proven record in executing large healthcare and SaaS commercial transactions.

Peter Hildebrandt, Chief Operations Officer

- **Tenure:** Appointed in Feb-20.
- **Previous Experience:** >20 years of international business experience facilitating innovative B2B technology companies across a range of industrial applications. Previously, CEO of Advanced Braking Technology and eHatsystems.

Mat Robie, Chief Commercial Officer

- **Tenure:** Appointed in May-24.
- **Previous Experience:** >20 years of US-specific healthcare experience as a healthcare consultant and executive director for a wide array of US HCOs. Expertise in areas of Medicare, Medicaid and commercial operations.

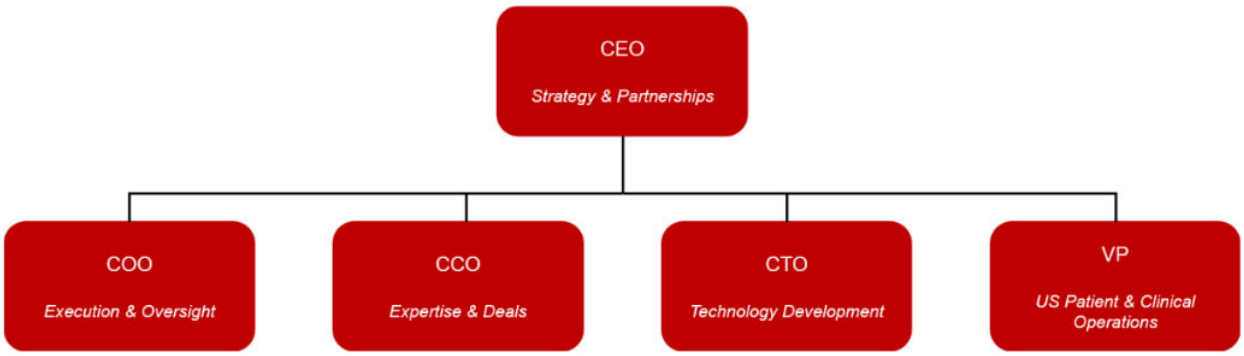
Eric Van Portfliet, Chief Technology Officer

- **Tenure:** Appointed in Sep-22 (at Orb Health, acquired by VHL Jan-25).
- **Previous Experience:** >40 years of experience as a software engineer and technology executive with a record of leading healthcare technology organisations. Has been the chief technology officer in four individual companies, most recently at Orb Health which was acquired by VHL.

Serena Gutierrez, Vice President (US Patient and Clinical Operations)

- **Tenure:** Appointed in May-25
- **Previous Experience:** >20 years of experience in population health, responsible for developing and executing clinical integration and quality outcomes in HCOs. Key focus area in VBC and achieving desirable outcomes for both patient and providers.

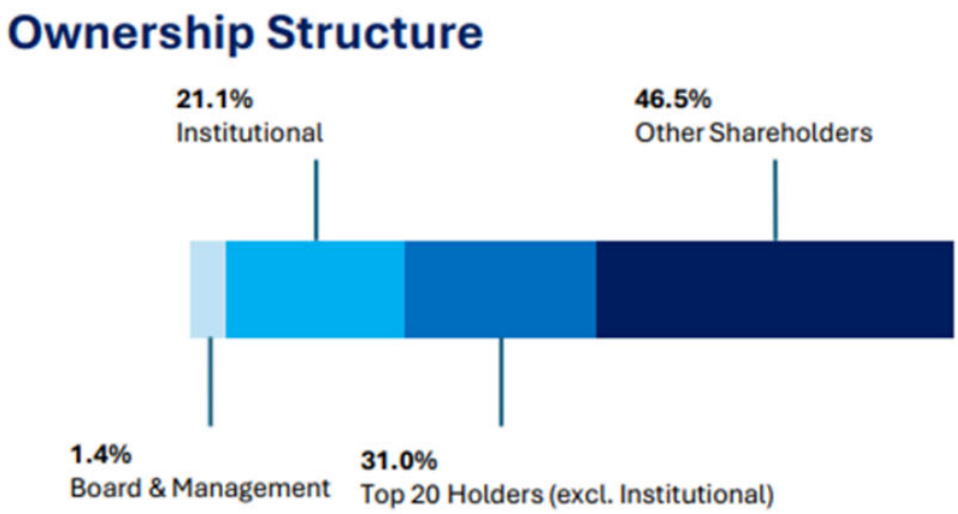
Figure 34: VHL management hierarchy



Source: MST

Substantial stockholders

Figure 35: VHL stockholder segmentation



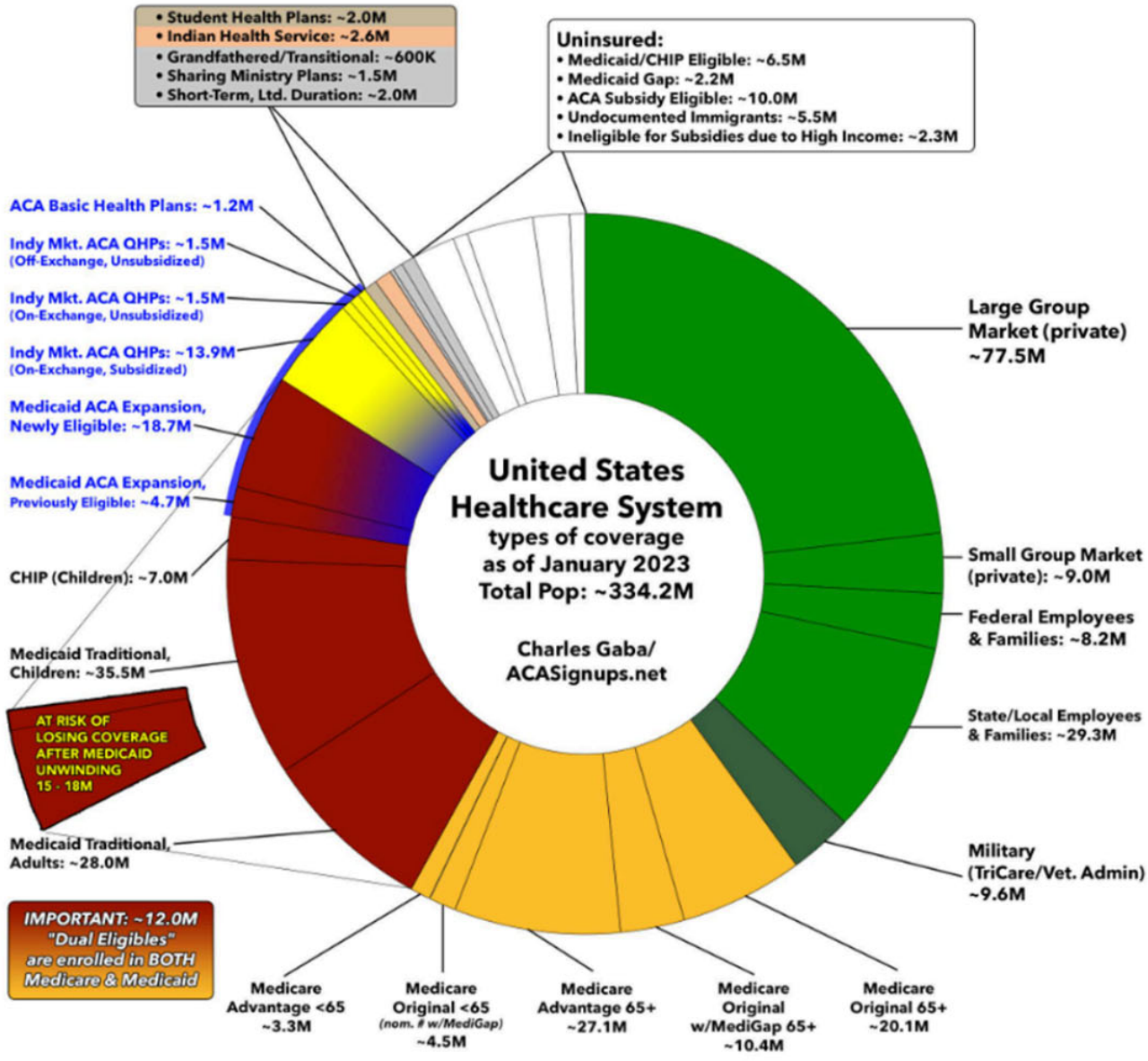
Source: VHL

Appendix A: US Healthcare System

Background – USA Health System [more detail Appendix A]

The US healthcare system is the world's largest, with **US$4.5tn in spending (17.3% of GDP)** in 2022, and projected to reach **20% of GDP by 2032.**

Figure 36: USA Healthcare Insurance Coverage – in detail (Green – Commercial; Yellow – Medicare; Red – Medicaid)

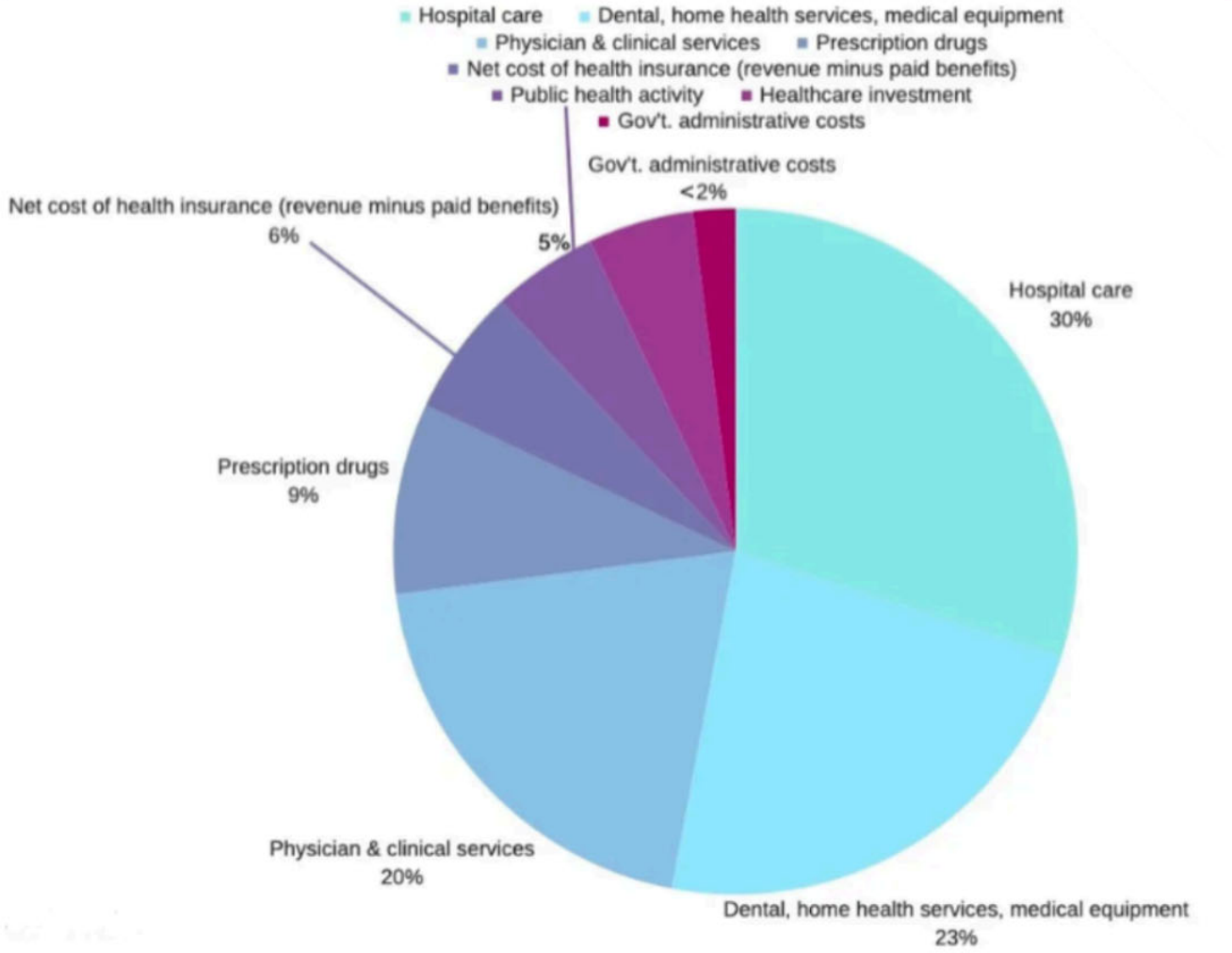


Source: ACA

Components:

- **Medicare**: Federal funded for over +65 yr olds. Covers **~68m** people (~60m aged 65+, ~8m disabled). Includes Parts A (hospital), B (outpatient), C (Medicare Advantage), and D (drugs).
- **Medicaid**: Co-funded Federal/State run covering the socially vulnerable. Covers **~93m** low-income individuals, including Children's Health Insurance Program (CHIP).
- **Private / Commercial insurance**: Covered **~182m** including employer-sponsored (self-insured) plans and Affordable Care Act (ACA) marketplace coverage-remains (24m people enrolled in ACA marketplace plans for 2025).

Figure 37: US Health Spending in 2022 was US$4.5tn



Source: CMS

Spending breakdown: Hospitals (30% of total Health system costs), physician services, drugs, and administrative overhead.

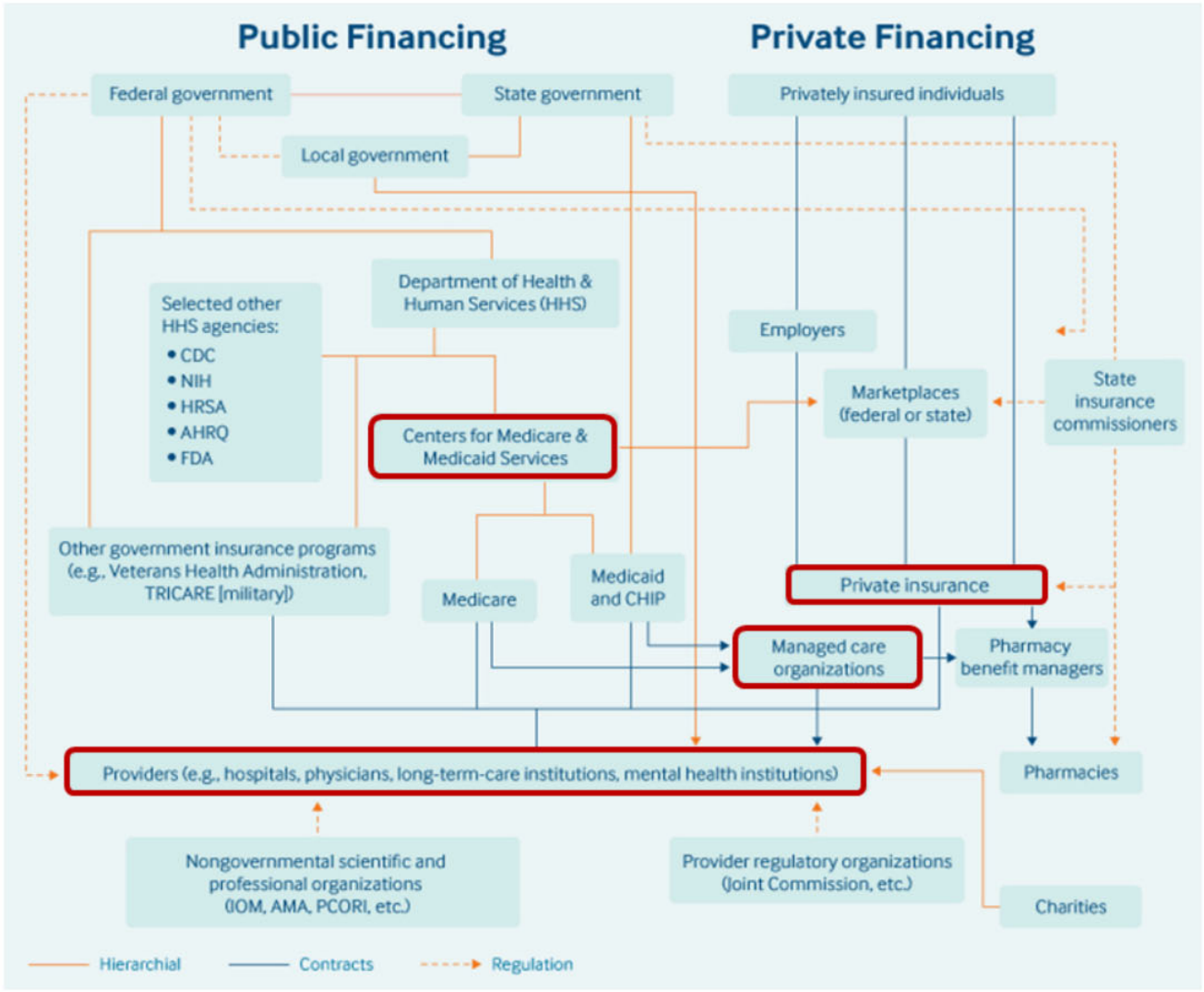
Growth outlook: Healthcare spending growth at 5.6% pa to outpace US GDP estimated at 4.3% pa through 2032, driven by aging population and chronic disease.

The future of the US healthcare system?

A fundamental issue in the US system is the persistence of fee-for-service reimbursement models, which incentivise volume over value. In response, the system is undergoing a material shift toward value-based care (VBC), a model focused on improving patient outcomes while controlling costs. A prime example includes the CMS's push for all Medicare patients to be in accountable care relationships by 2030.

The shift to VBC will be measured and enforced by CMS, which as the regulator and funder of Medicare, sets reimbursement rules, mandates accountable care participation, and monitors provider performance. This is achieved through regulatory mandates (e.g. MSSP), outcome-linked payment models (such as capitated and risk-share), performance measurement (including care benchmarks, HRRP penalties, and Star Ratings), and audits to ensure cost and quality compliance.

Figure 38: Organisation of the US healthcare system including VHL's target clients



Source: The Commonwealth Fund

US Health Policy – 'Make America Healthy Again'

Recent policy initiatives have reaffirmed the pivot toward VBC. Under the leadership of HHS Secretary Robert F. Kennedy Jr. and CMS Administrator Dr Mehmet Oz, policy platforms have focused on:

- Replacing reactive treatment with preventive care
- Aligning provider incentives with outcomes rather than procedures
- Enhancing informatics and transparency in provider performance
- Reducing systemic inefficiencies, fraud, and unnecessary expenditure
- Empowering patients with personalised health navigation tools

Presidential policy direction has reinforced these efforts. In early 2025, President Trump signed an executive order launching a chronic disease taskforce aimed at targeting preventable illness, while Secretary Kennedy highlighted the need to dismantle "perverse incentives" in the current reimbursement architecture. Dr Oz has further outlined the commitment of the CMS to personalised health navigation, fraud elimination, and structural reform of care delivery.

Figure 39: Recent US legislation developments pertaining to RPM and Telehealth with bipartisan support

Date	Act	Purpose
Sep-23	Expanding Remote Monitoring Access Act	Proposed easing RPM billing requirements by reducing minimum data collection from 16 days to 2 days per month, improving accessibility for providers and patients.
Dec-24	American Relief Act of 2025	Extended Medicare telehealth flexibilities until 30 September 2025, preserving access to virtual care during policy transition.
Apr-25	Rural Patient Monitoring Access Act	Introduced national minimum reimbursement rates to improve RPM access for Medicare patients in rural and underserved communities.

Source: US Congress

Recap – Structural megatrends in US healthcare

Key macro-level trends are accelerating VBC adoption and creating opportunities for technology providers such as VHL:

1. **Rising Medicare/Medicaid Enrolments:** Increasing fiscal pressure is driving innovation in care delivery and reimbursement models for the US government, but also for healthcare providers and healthcare payers.
2. **Growth of Capitated Insurance Models:** Commercial payers are shifting toward population health management rather than activity-based billing which occurs per service.
3. **Acceleration of RPM and Telehealth:** Catalysed by COVID-19 and supported by bipartisan regulation, RPM is quickly becoming standard care infrastructure.

Overview of CMS (Medicare and Medicaid) Reimbursement

Medicare (CMS) Coverage

RPM is an established and reimbursable service under Medicare across all 50 US states, first reimbursed in 2019. CMS supports RPM as part of its broader shift towards value-based and preventive care models. RPM services are reimbursed through specific CPT codes covering device setup, data transmission, and ongoing clinical management. Providers are typically paid on a per patient per month (PPPM) basis, which aligns well with chronic disease management. Eligible patients generally include those with chronic or acute conditions, with data collection required regularly, though proposed changes may soon lower these thresholds to expand access further.

Medicaid Coverage

RPM reimbursement under Medicaid is determined at the state level. As of Jan-25, 42 states provide Medicaid coverage for RPM services. While not yet universal, this reflects growing recognition of RPM's value in improving outcomes and reducing avoidable hospitalisations, particularly in high-risk and underserved populations.

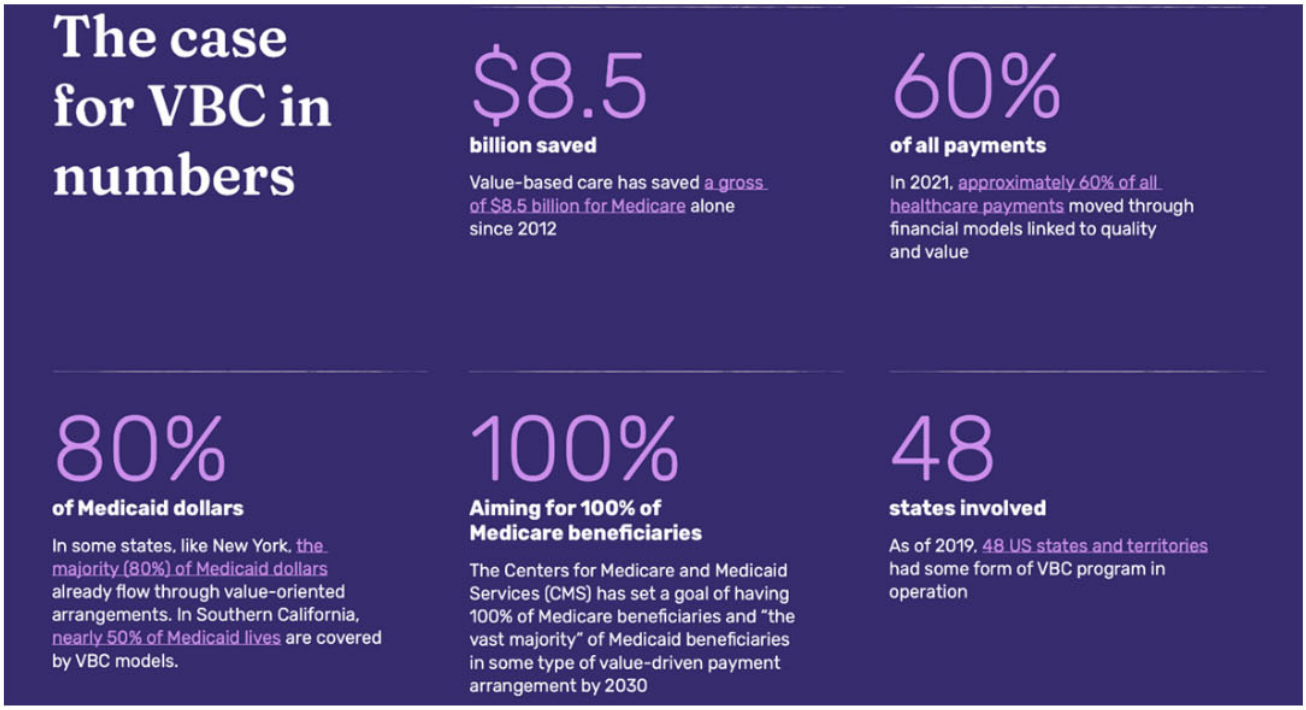
Private Insurers

Many commercial insurers now reimburse RPM, often aligning closely with Medicare's CPT framework. This reflects increasing acceptance of RPM's role in managing chronic conditions, improving patient outcomes, and helping to contain long-term healthcare costs.

Clinical Evidence Supports Personalised Remote Care

A growing body of clinical research underscores the effectiveness of RHS and personalised care models in improving outcomes for chronic disease patients. Peer-reviewed studies have shown that tailored remote monitoring can reduce hospitalisations, improve adherence, and enhance patient engagement, particularly among high-risk groups. For example, BMC Health Services Research reported that RPM for congestive heart failure and COPD patients reduced mortality and readmissions, while a BMJ Open systematic review confirmed RPM's ability to decrease acute care use in chronic conditions such as COPD. VHL's integrated platform, combining patient-specific care plans, clinical oversight, and accessible medical devices, is aligned with these best practices, and positioned as a clinically validated solution for CCM.

Figure 40: Benefits of the VBC model



Source: Yuvo Health

The Value-Based Care Ecosystem – Client Targets for VHL

1. Accountable Care Organisations (ACOs)

ACOs are collaborative networks of physicians, hospitals, and post-acute providers established under the Affordable Care Act in 2010 to improve care coordination and reduce healthcare costs. Their core mandate is to manage the total cost and quality of care for Medicare beneficiaries under shared savings or downside-risk contracts.

Business Model

To participate in value-based contracts, ACOs must manage a minimum of 5,000 attributed Medicare lives and meet specific quality and cost benchmarks. Their revenue model combines per member per month (PMPM) capitation payments with performance bonuses linked to clinical outcomes and cost savings. As ACOs scale, they benefit from enhanced operational leverage through data analytics, remote monitoring, and population health management infrastructure. Many ACOs have expanded beyond Medicare to engage in commercial and Medicaid contracts, increasingly adopting services such as RPM and CCM to improve outcomes for high-risk populations.

2. US Health Insurers

US health insurers such as UnitedHealth (via Optum), Elevance (Anthem), Humana, and Cigna operate highly integrated business models that combine insurance, provider networks, and health technology. Unlike Australian private health insurers, which are primarily reimbursement entities, US payers play an active role in care delivery and chronic disease management.

Business Model

These organisations receive capitated or risk-adjusted payments for managing lives across Medicare Advantage, Medicaid Managed Care, and commercial plans. Their financial model is underpinned by scale, larger member bases allow for more accurate risk pricing, enhanced negotiating power with providers, and increased investment in predictive analytics. Many insurers own or contract with provider groups (e.g., OptumCare, CenterWell), allowing them to directly control service delivery, reduce cost leakage, and retain value within their ecosystem. Their technological capabilities, especially in data-driven care navigation and fraud detection, support improved clinical outcomes and financial performance under VBC arrangements.

3. Independent Physician Associations (IPAs)

IPAs are networks of autonomous physicians that band together to negotiate payer contracts and gain access to administrative scale without sacrificing professional independence. IPAs play a growing role in value-based care by enabling smaller practices to participate in risk-sharing models.

Business Model

IPAs contract with Medicare Advantage plans, ACO programs, and commercial payers to access value-based reimbursement structures. They serve as administrative platforms that support physicians in billing, compliance, and population health initiatives. Increasingly, IPAs are evolving into Management Services Organisations or forming their own ACO entities. Many are adopting centralised tools for RPM and CCM delivery, positioning themselves as agile partners for infrastructure providers like VHL. Their decentralised, scalable structure makes them ideal channels for deploying virtual care solutions at scale.

4. **Hospital Systems and Integrated Delivery Networks (IDNs)**

Hospital systems in the US, often organised as IDNs such as the Mayo Clinic, encompass a wide range of services including acute care, outpatient clinics, rehabilitation, and home health. Many such as Geisinger Health System also operate their own health plans, effectively combining provider and payer functions under one umbrella.

Business Model

Traditionally reliant on fee-for-service revenue, hospital systems are increasingly adopting VBC models through participation in ACOs, Medicare Advantage, and provider-sponsored insurance plans (e.g., Kaiser Permanente). With over 40% of US physicians now employed by health systems, these entities control significant delivery infrastructure and influence over care pathways. While they possess large capital budgets and comprehensive technology stacks, adoption of third-party solutions can be slow due to complex procurement processes, EMR integration challenges, and organisational silos. Still, hospital systems are critical to scaling VBC initiatives, particularly for high-cost, high-utilisation patient cohorts.

5. Primary Care Providers (PCPs)

PCPs serve as the initial point of contact in the US healthcare system and are increasingly central to VBC strategies. They play a critical role in preventive health, chronic disease management, and care coordination.

Business Model

PCPs generate revenue through traditional fee-for-service billing (including CPT codes for RPM, CCM, and TCM) as well as through capitation and shared savings agreements under Medicare Advantage and ACO frameworks. Many PCPs have integrated remote monitoring and care coordination services into their workflows, unlocking new income streams while meeting quality targets. The sector is experiencing a shift toward tech-enabled, vertically integrated models exemplified by providers such as Oak Street Health and ChenMed, who focus on high-risk populations and generate strong returns through proactive, data-driven care management.

Figure 41: Traditional fee-for-service vs VBC model

In a traditional fee-for-service model:

Providers are incentivized to focus on treating a higher volume of patients.

A patient visits a provider to resolve a specific health question or problem.

The patient receives treatment and is billed for the visit or service.

The three focus areas of value-based-care

Value-based care models help providers focus on **3 areas** to better serve patients:

QUALITY

COST

EQUITY

In a value-based care model:

The emphases are on access to care, coordination of care, patient experience, and overall health outcomes.

A provider can proactively reach out to patients to schedule and perform appropriate preventative care, manage chronic conditions, or monitor health risks.

Providers can spend more time with each patient with less administrative burden to help ensure the best health outcomes.

A provider can work with a patient's other care providers using a team approach to coordinate care management, monitor medication adherence, or consider support for health-related social needs.

Providers can consider needs related to patients' social determinants of health (such as food insecurity or transportation limitations) and connect patients with resources and services (such as wellness and behavioral health programs or community support resources).

Providers can focus on population health management by reviewing the needs of their patient population rather than just those who seek care.

Providers have more decision-making ability to manage and enhance the efficiency, flexibility, quality, cost, and perception of the care they provide

Source: Relias

Vitasora Plays a Key Role in Value-Based Care

Direct Participation in VBC

VHL is not simply a vendor of RPM solutions, but a direct operator and enabler within the VBC ecosystem. Through its integrated platform and commercial model, VHL engages across multiple strategic dimensions that align it with the structural shift in US healthcare toward outcomes-based reimbursement and chronic care optimisation. It can provide RPM services to any healthcare organisation (HCO) located in the US.

1. Risk-Share Agreements

VHL partners directly with ACOs and payers through per patient per month (PPPM) fees, complemented by shared savings models. This structure directly aligns VHL's revenue with its ability to reduce hospitalisations and improve patient outcomes, reflecting a shift from transactional to performance-based reimbursement.

2. Outcome-Driven RPM & Care Coordination

At the centre of VHL's offering is an integrated care model that combines the proprietary Wheezo device, cloud-based clinical software, and a centralised care team. This model has delivered demonstrable clinical results, including hospitalisation reductions of more than 50% among targeted patient cohorts. By supporting timely interventions and ongoing disease management, VHL enhances clinical outcomes while reducing costs for the healthcare system.

3. Virtual Care Enablement via Clinic-in-Cloud

In addition to direct care delivery, VHL serves as a virtual infrastructure partner to ACOs, IPAs and PCPs. Through its platform, VHL enables downstream providers to deliver and bill for chronic care services, including RPM and CCM. This supports scalable VBC participation across fragmented provider networks.

4. Targeting High-Cost Populations

VHL's platform is tailored to manage patients with chronic diseases such as COPD, asthma, diabetes, and hypertension, chronic conditions that disproportionately contribute to overall healthcare costs. By focusing on the 8–15% of patients who typically account for approximately 50% of spend, VHL maximises the value capture potential of its solutions and delivers targeted interventions where they matter most.

5. Driving Patient Engagement and Behavioural Change

A critical success factor in VBC is ensuring patient activation and adherence to prescribed care plans. VHL's platform fosters engagement through personalised monitoring, educational resources, and regular clinical interactions via its remote care teams. This approach improves self-management and reduces preventable exacerbations, addressing one of the key barriers to sustainable cost reduction in CCM.

The Role of Vitasora's Universal Patient Engagement Centre

As the US healthcare system shifts towards VBC, greater emphasis is being placed on preventive services and accurate clinical coding to align provider incentives and optimise reimbursement. Annual Wellness Visits (AWVs), fully covered by Medicare, have emerged as a critical tool in this landscape. AWVs enable providers to conduct comprehensive patient assessments, identify risk factors, and create prevention-focused care plans. Importantly, they also serve as a key input mechanism for updating ICD-10 codes and capturing accurate Hierarchical Condition Category (HCC) risk scores, which directly influence capitated payments and shared savings calculations under VBC models.

Recognising this, VHL has plans to integrate AWVs into its offering through the Universal Patient Engagement Centre (UPEC), a platform designed to streamline patient outreach, scheduling, and follow-up. UPEC enhances provider efficiency and patient compliance as a cross-selling opportunity, ensuring that AWVs are performed consistently across eligible populations. This supports more accurate ICD-10 and HCC coding, which in turn allows payers and providers to receive appropriate risk-adjusted payments. Plus, regular patient interaction through AWVs promotes early detection, strengthens care coordination, and reinforces adherence to care plans, aligning closely with the objectives of ACOs, Medicare Advantage plans, and other VBC programs.

In more detail – CMS Reimbursement, Billing with CPT Codes

VHL derives a significant portion of its revenue through reimbursement from the CMS, using standardised Current Procedural Terminology (CPT) codes. These codes enable billing for key remote care services, including device setup, data transmission, clinical oversight, and ongoing care coordination. VHL's model is tightly aligned with this structure, particularly under its Clinic-in-Cloud and risk-share offerings, allowing clients to capture CPT-linked revenue without assuming the clinical workload.

By delivering both RPM, CCM, PCM, RTM, and TCM services via its integrated platform and trained clinical staff, VHL facilitates scalable, compliant, and profitable participation in Medicare's VBC programs. Upcoming changes to CPT requirements by the AMA in Jan-26 are expected to further reduce compliance barriers and expand eligibility, improving the outlook for VHL.

Billing requirements for CMS:

- Documented patient consent
- Comprehensive care plan (required for CCM/PCM; recommended for RPM/RTM)
- Certified EHR documentation (mandatory for CCM; recommended for others)
- Minimum time thresholds must be met for time-based codes
- 24/7 care coordination (mandatory for CCM and PCM; RPM/RTM focus on active monitoring)

Figure 42: Billing CPT codes which are filed with the CMS for reimbursement in 2025

Service	CPT Code	Description	Estimated Reimbursement (USD)
Remote Patient Monitoring (RPM)	99453	Initial setup and patient education	~$20 (one-time)
	99454	Device supply with daily recordings/transmissions (30 days)	~$43/month
	99457	First 20 minutes of monitoring and management	~$48/month
	99458	Each additional 20 minutes	~$38/month
Chronic Care Management (CCM)	99490	First 20 minutes of non-complex CCM	~$60/month
	99439	Each additional 20 minutes of non-complex CCM	~$46/month
	99491	First 30 minutes of complex CCM by physician	~$82/month
	99437	Each additional 30 minutes of complex CCM by physician	~$59/month
	99487	First 60 minutes of complex CCM by clinical staff	~$132/month
	99489	Each additional 30 minutes of complex CCM by clinical staff	~$71/month
Principal Care Management (PCM)	99424	First 30 minutes of PCM by physician	~$82/month
	99425	Each additional 30 minutes of PCM by physician	~$59/month
	99426	First 30 minutes of PCM by clinical staff	~$60/month
	99427	Each additional 30 minutes of PCM by clinical staff	~$46/month
Remote Therapeutic Monitoring (RTM)	98975	Initial setup and patient education	~$20 (one-time)
	98976	Device supply for respiratory system monitoring (30 days)	~$39/month
	98977	Device supply for musculoskeletal system monitoring (30 days)	~$39/month
	98980	First 20 minutes of RTM management services	~$50/month
	98981	Each additional 20 minutes of RTM management services	~$41/month
Transitional Care Management (TCM)	99495	TCM with moderate complexity decision-making	~$176 (per episode)
	99496	TCM with high complexity decision-making	~$237 (per episode)

Source: CMS, MSTe

What is a chronic condition according to the CMS?

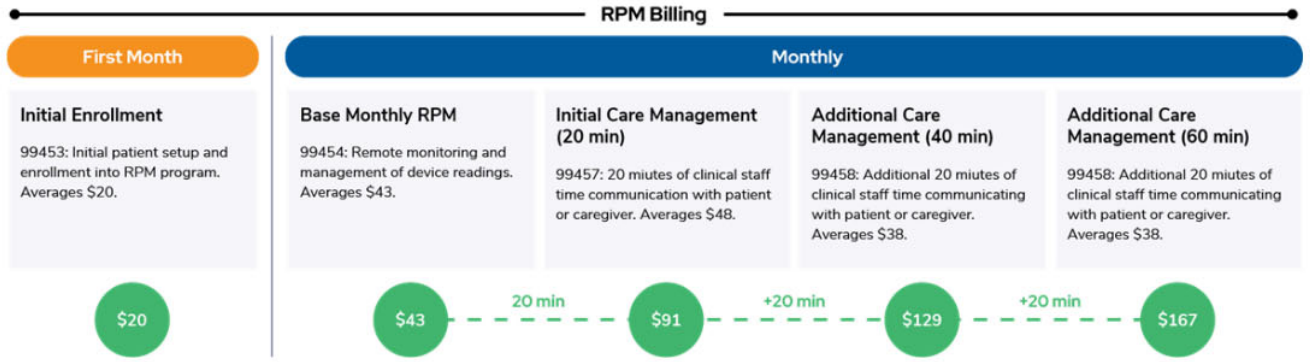
Per CMS, a chronic condition must

- Last ≥12 months (or until death) and
- Pose significant risk of death, acute exacerbation, or functional decline.

Examples include Alzheimer's disease, arthritis, asthma, atrial fibrillation, cancer, COPD, depression, diabetes, heart failure, hypertension, HIV/AIDS, osteoporosis, and stroke.

Patients require ≥2 documented chronic conditions in their medical record for CCM reimbursement via CPT codes, with diagnoses aligned to ICD-10 coding at their annual wellness check.

Figure 43: Indicative RPM billing journey for each patient with additional billing opportunities if the patient falls under CCM



Source: Prevounce

How multiple billing codes may be applied

Case Study - A patient with multiple chronic conditions being monitored remotely by VHL may be reimbursed under the following Medicare billing codes (excluding other risk-based payments for capitated payment plans):

- **RPM: 99453/99454** - For device setup and monthly data transmission.
- **RPM: 99457/99458** - For providing 20+ minutes of care management per month.
- **CCM: 99490** - For providing 20 minutes of non-complex chronic care management per month.
- **CCM: 99487/99489** - For providing 60+ minutes of complex chronic care management by clinical staff.

Appendix B: VHL Revamped Business Model

Medtech Oriented Connected Care Management

VHL is a medtech-enabled healthcare company delivering RPM solutions for chronic disease management across multiple high-burden conditions. While the company is best known for its proprietary Wheezo device and clinical strength in managing respiratory disorders such as asthma and COPD, its platform is designed to support a broad spectrum of chronic conditions, including diabetes, hypertension, obesity, and congestive heart failure, which together account for the majority of preventable hospital admissions and healthcare expenditure in the US.

Key components of VHL's chronic care model include:

Targeting High-Risk Populations - VHL focuses on patients with complex, high-cost chronic conditions, including but not limited to asthma, where exacerbations and unmanaged symptoms frequently lead to avoidable hospital admissions. By stratifying patient cohorts based on historical utilisation and comorbidity profiles, the platform is designed to prioritise those most likely to benefit from continuous remote oversight.

Accurate Health Decline Detection - The Wheezo device offers continuous, passive monitoring of respiratory symptoms, but the broader platform also integrates biometric data across other chronic conditions. By using structured inputs and AI-driven alerts, VHL enables early detection of deterioration, triggering timely clinical interventions.

Responsive & Timely Care - All patient-generated data is transmitted in real time to healthcare providers and care coordinators, facilitating proactive management based on real-world trends rather than retrospective check-ups. This immediacy is particularly important for conditions prone to acute flare-ups or medication non-compliance.

Personalised and Adaptive Care - Care delivery is customised at the patient level, incorporating preferences, medication regimens, social determinants of health, and digital literacy. This tailored approach improves adherence, reduces dropout rates, and supports scalable clinical oversight across diverse patient populations.

Enhanced Self-Management - Through its mobile app and patient-facing interfaces, VHL empowers individuals to monitor their condition, recognise warning signs, and maintain better health behaviours. This has been shown to improve health literacy, reinforce positive habits, and drive long-term outcomes across both respiratory and metabolic conditions.

Collaborative & Coordinated Care - The VHL platform is designed to support care team collaboration. Providers can access longitudinal data, review historical trends, and adjust care plans in coordination with VHL's clinical staff. This shared visibility ensures consistency across providers, supports multidisciplinary care, and enables data-informed clinical decision-making at scale.

Figure 44: Gold standard for RPM program design according to a peer-reviewed systematic review

Source: VHL, BMJ Open

Superior Engagement and Persistence Metrics

One of the critical differentiators of VHL's offering is its ability to sustain long-term patient engagement, a common weakness among remote care programs. Internal data indicates:

Persistence: Patients remain in the program on average 90% longer than the national CMS benchmark, highlighting the robustness of VHL's onboarding, monitoring, and support architecture.

Engagement: The company has reported a 98% engagement rate, underscoring its effectiveness in maintaining regular device usage and patient communication.

This high adherence underpins the VHL's value proposition in the current fee-for-service and risk-based reimbursement environments, where program efficacy directly drives financial outcomes.

Vitasora's internal data demonstrates success in VBC for contracted clients

Key outcomes achieved by clients include:

- 56% reduction in hospitalisations
- 42% reduction in medication compliance
- 47% reduction in emergency room visits
- 91% improvement in medication compliance

Noting, this data approximately corresponds with other competitors on the market and their purported rates of reductions in hospitalisations etc. The key takeaway is that Remote Healthcare Solutions (RHS) are an effective tool in assisting with the management of chronic conditions, a critical component of VBC. This is supported by an array of clinical evidence from academic literature, such as the BMJ.

Moreover, as per the CMS, it has identified with high confidence that its CCM services program has reduced costs by US$74 per beneficiary/patient per month. This highlights the alignment between favourable clinical and cost outcomes in the management of chronic care.

Connected Care Management – Client and Patient Journey

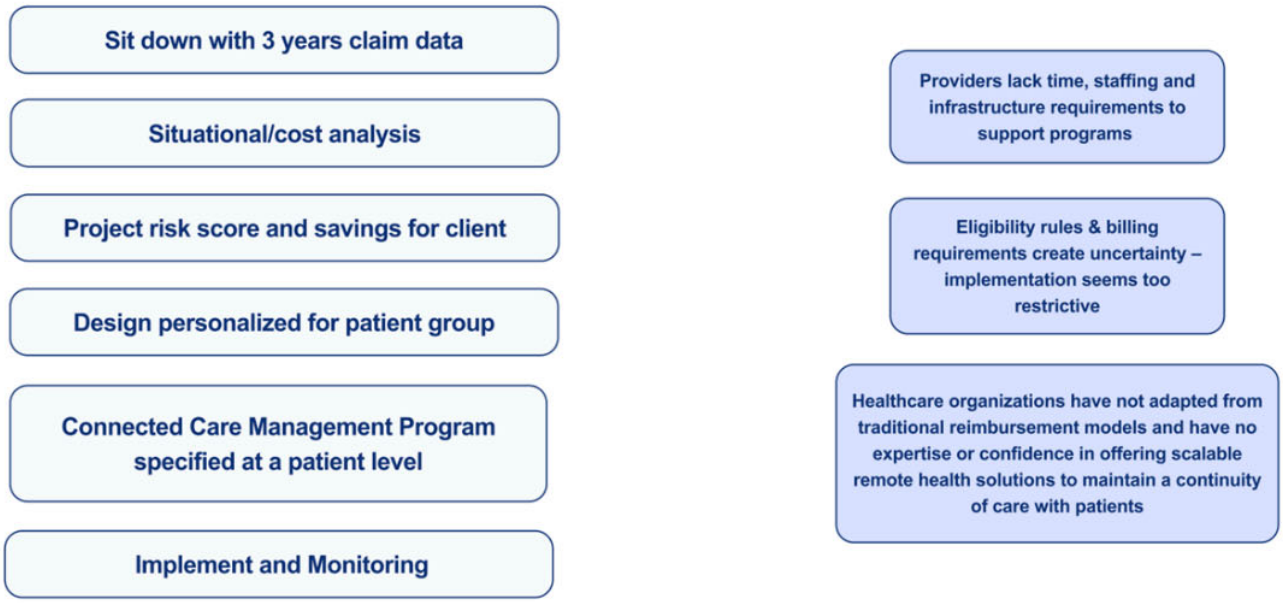
Client Perspective

VHL's Connected Care Management Program begins with a retrospective review of 3 years' worth of healthcare claims data to identify cost drivers, utilisation patterns, and savings opportunities. From this, risk stratification and projected financial impact are calculated, allowing the program to target high-acuity patients where intervention will be most effective.

A population-level care plan is then tailored to the needs of individual patients, including remote monitoring protocols, escalation pathways, and clinical workflows. Implementation includes end-to-end monitoring, integration with clinical teams, and iterative refinement based on real-time outcomes. The structure is designed to support both Medicare fee-for-service and VBC frameworks.

Despite its effectiveness, barriers to broader uptake remain, including provider resource constraints, CPT billing complexity, and hesitancy to transition to value-based reimbursement models. VHL's turnkey solution mitigates these frictions by simplifying adoption and delivering immediate workflow support.

Figure 45: A client journey with VHL



Source: VHL

Patient Perspective

From a patient standpoint, the process begins with identification and eligibility screening. This includes clinical data review, risk categorisation, and the collection of demographic and medical history. Once eligibility is confirmed, patients are enrolled and consent to VHL's RPM.

Device onboarding follows, where patients are trained in the use of RPM equipment (including the Wheezo device), monitoring cadence, and expectations for telehealth interactions. Routine data collection, check-ins by clinical staff, and escalation protocols are embedded throughout the process. In-person or telehealth visits are layered on top of the remote monitoring cadence to further refine care delivery.

This end-to-end pathway ensures continuity of care, enhances early detection of deteriorating health, and reduces the burden on overstretched healthcare systems.

Vitasora's Revenue Models

Vitasora has established three distinct monetisation pathways, each aligned to different segments of the healthcare reimbursement landscape:

1. Fee-for-Service (Traditional Model) – US$70–100 per patient per month (PPPM)

In this model, healthcare providers outsource RPM delivery to VHL and bill CMS directly using standard CPT codes. VHL is paid approximately 60% of the reimbursed amount, equating to US$70–100PPPM depending on care complexity and code mix. The model offers an immediate revenue opportunity but is subject to administrative burden and delayed cash conversion due to third-party billing owing to the healthcare provider. Should proposed CPT code updates from the AMA be enacted, this model's revenue potential could increase by US$70–90PPPM

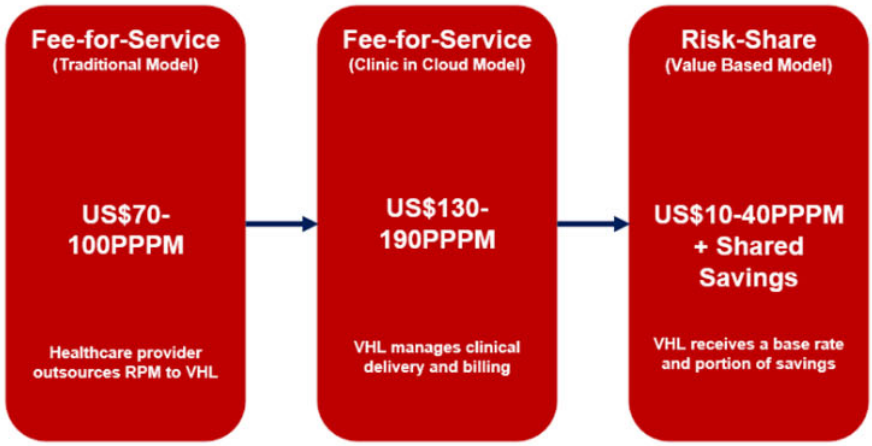
2. Fee-for-Service (Clinic-in-Cloud Model) – US$130–190PPPM

The Clinic-in-Cloud model represents an advanced, vertically integrated fee-for-service solution in which VHL manages both clinical delivery and end-to-end billing. Retention rates for CPT reimbursements increase to 85–95%, translating to revenue of US$130–190PPPM. By owning the billing infrastructure, VHL significantly improves its working capital profile while relieving providers of administrative overhead. This model is particularly attractive to ACOs, IPAs, and PCPs managing large chronic populations. Again, should proposed CPT code updates from the AMA be enacted, this model's revenue potential could increase by US$70–90PPPM

3. Risk-Share (Value Based Model) – US$10–40PPPM + Shared Savings (US$160-250PPPM)

Under the VBC model, VHL is reimbursed through a fixed PPPM base (US$10–40) plus a share of savings generated through improved outcomes and reduced utilisation. If top-tier patient engagement for the 'high-risk' patients is achieved, effective revenue can scale to US$160–250PPPM in additional shared savings factoring a 8-15% engagement rate, reflecting the upside of targeting high-cost populations. This model aligns incentives across VHL, payers, and providers, and is best suited to Medicare Advantage and capitated plans such as the Medicare Shared Savings Program (MSSP). Its success hinges on VHL's ability to drive measurable cost savings through clinical performance, else it may share in the losses.

Figure 46: Snapshot of the three revenue models (Jan-26 AMA changes may increase fee-for service by US$70-90PPPM



Source: VHL

Appendix C: Glossary of Terms and Abbreviations

ACO (Accountable Care Organisation)

A network of healthcare providers that coordinate care for Medicare patients, aiming to reduce costs and improve outcomes while sharing any savings.

AMA (American Medical Association)

The leading US medical association representing physicians, promoting medicine and public health.

AWV (Annual Wellness Visit)

An annual Medicare-covered preventive service to develop or update a personalised prevention plan.

Capitated Payments

Upfront, risk-adjusted payments to providers to cover predicted patient care costs, promoting proactive and comprehensive care.

CCM (Chronic Care Management)

A Medicare program supporting patients with multiple chronic conditions through coordinated, non-face-to-face care.

CMS (Centres for Medicare and Medicaid Services)

The US federal agency administering Medicare, Medicaid, and related healthcare programs.

COPD (Chronic Obstructive Pulmonary Disease)

A chronic lung disease causing airflow obstruction and breathing difficulties.

CPT (Current Procedural Terminology)

AMA-developed medical codes used to document and bill healthcare services and procedures.

EMR (Electronic Medical Record)

A digital version of a patient's paper chart used within a healthcare practice.

Fee-for-Service Payments

A payment model where providers are reimbursed per service delivered.

HCC (Hierarchical Condition Category)

A risk-adjustment model estimating future healthcare costs based on patient conditions.

HCO (Healthcare Organisation)

An entity providing health services, including hospitals, clinics, and medical practices.

HIPAA (Health Insurance Portability and Accountability Act)

US legislation safeguarding patient medical information privacy and security.

Hospital System / IDN (Integrated Delivery Network)

A coordinated network of care facilities offering a full continuum of services, aiming for efficiency and integrated care delivery.

HRRP (Hospital Readmissions Reduction Program)

A Medicare initiative penalising hospitals with high 30-day readmission rates to incentivise better discharge and post-acute care.

ICD-10 (International Classification of Diseases, 10th Revision)

A global coding system for diagnoses and procedures, widely used for billing and care management.

IPA (Independent Physician Association)

A collective of independent medical practices contracting with health plans while maintaining practice autonomy.

MSSP (Medicare Shared Savings Program)

A CMS program rewarding ACOs that lower costs while meeting care quality standards.

PCM (Principal Care Management)

A Medicare service for patients with a single high-risk condition, offering monthly care coordination.

PCP (Primary Care Provider)

The first point of medical contact, providing general, preventive, and ongoing care.

PMPM (Per Member Per Month)

A fixed monthly payment for each person enrolled, paid whether or not they receive care. Common in value-based care and capitated contracts.

PPPM (Per Patient Per Month)

A monthly payment made only when care is actively provided to a patient. Common in Medicare fee-for-service billing.

RHS (Remote Healthcare Solution)

Technology platforms enabling remote delivery of care, such as telehealth and RPM.

RPM (Remote Patient Monitoring)

Digital monitoring of patient health data outside clinical settings to support proactive care.

RTM (Remote Therapeutic Monitoring)

Digital health services tracking non-physiological data (e.g., adherence, therapy response) using connected devices.

TCM (Transitional Care Management)

A Medicare program supporting patients transitioning from hospital to home, aiming to prevent readmissions.

UPEC (Universal Patient Engagement Centre)

A technology platform improving patient engagement, facilitating services like AWVs and helping providers optimise reimbursement.

VBC (Value-Based Care)

A care model that ties provider payment to patient outcomes, incentivising quality, efficiency, and long-term health improvements over service volume.

Personal disclosures

Andrew Goodsall received assistance from the subject company or companies in preparing this research report. The company provided them with communication with senior management and information on the company and industry. As part of due diligence, they have independently and critically reviewed the assistance and information provided by the company to form the opinions expressed in this report. They have taken care to maintain honest and fair objectivity in writing this report and making the recommendation. Where MST Financial Services or its affiliates has been commissioned to prepare content and receives fees for its preparation, please note that NO part of the fee, compensation or employee remuneration paid has, or will, directly or indirectly impact the content provided in this report.

Company disclosures

The companies and securities mentioned in this report, include:

Vitasora Health Ltd (VHL.AX) | Price 0.043 | Valuation 0.120;

Price and valuation as at 19 May 2025 (not covered)*

Additional disclosures

Within the past 12 months, MST and its associates have provided and received compensation for investment banking services, including acting as Lead Manager for the March 2025 capital raising of A$4 million for Vitasora Health Ltd (VHL.AX), formerly Respiri (RSH.AX) at time of capital raising.

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