3/22/2021

Lake Cornelia Research Management, Inc.
Stock: Cano Health ("CANO") or Jaws Acquisition ("JWS")
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Disclaimer: I am not a sell side analyst. The information herein is for discussion purposes only. Investors are encouraged to do their own work before transacting in any securities mentioned. Investing in the stock market includes risk, including the risk of loss. A full disclaimer is at the end of the memo. Please read it before proceeding.

Notes:

- *JWS is a SPAC that is merging with CANO. Post the de-spac, the ticker will change from JWS to CANO.*
- *While I have some background information on the industry, OSH and Direct Contracting, I encourage you to read the ample amount of research available on these topics*

I am long JWS/CANO. My target price is $30 post de-spac vs. $13.00 currently. As we approach the closing of the SPAC transaction, there are multiple catalysts to drive JWS/CANO higher. Additionally, unlike many SPACs, CANO benefits from a pure play comparable public company, Oak Street Health ("OSH") of roughly equivalent size and business characteristics.

The elevator pitch for JWS/CANO:

> *JWS/CANO is de-SPACing in late April/May.* ***It trades at greater than a 50% discount to pure play comparable OSH****. OSH is a great investment in its own right, and 11/12 analysts have buy ratings owing to the considerable industry tailwinds that both JWS/CANO and OSH are exposed to. The biggest tailwinds are: (1) growing penetration of Medicare Advantage, (2) the shift to value-based care models and (3) aging population. JWS/CANO and OSH should be multi-baggers over time. JWS/CANO should close much of the valuation gap to OSH post the de-SPAC, generating a near term 50-100% return, and then grow in line with, or faster than, the industry over time.*

CANO is primary care provider for Medicare patients. It is part of the growing trend towards value-based care; CANO is compensated through a fixed, or capitated, per member / per month payment from insurance companies. CANO, and its peers, assume all risk, and reap all benefits from providing care at a lower cost than their capitated payment. This structure incentivizes value-based care providers to invest in preventative care and increase patient interactions. Value-based care providers have substantially increased patient outcomes, at lower costs compared to traditional Medicare. CANO is based in South Florida and has an extra focus on dual eligible Medicare / Medicaid patients (~50% of total members), as well as the Hispanic population.

In evaluating SPACs, I use a 7-point checklist:

Checklist Item	**Comment**
1. Could the company have done an IPO?	Yes, CANO could have easily executed an IPO. It has a pure play comp in OSH that was warmly received by the public markets in 2020. It has a pro-forma EV, at deal price, of over $4 billion and did over $800 million of revenue last year. Management is credible and ready for the public markets. CANO will be included in the Russel 2000 as well as potentially the S&P Midcap 400.
2. Did the company choose to SPAC for a non-financial reason?	Yes, CANO was in the middle of a private equity sales process and, per my diligence, had received 2-3 formal bids for the company. With CANO's largest shareholder being a private equity firm, there was a great desire to get increased assurance on public market's valuation, as well as certainty of execution that only a SPAC can provide (as compared to a traditional IPO)
3. Had the company pursued an IPO, would the stock have traded above $25 on a "SPAC equivalent basis…"ie $10 is the offer price?	Yes, the valuation of comparable OSH supports a valuation above $30. Additionally, I think the Hispanic focus has ESG tailwinds that may further support a premium public market's valuation. It is notable that multiple investors have filed 13Gs in JWS subsequent to deal announcement. ArrowMark (Denver Mutual Fund), Citadel, Diameter (sharp credit shop that does deep fundamental work), Third Point (in the PIPE and added further) and Fidelity (in the PIPE and added further).
4. Is the company a growth asset (as opposed to a value asset)?	Growth. Historical revenue CAGR is over 70%, and organic growth has been over 40%. This is a multi-year, perhaps decades long, growth story with multiple legs. Competitor OSH trades on an EV/Revenue multiple and has negative EBITDA for context.
5. Can this be worth $40 in two years?	Yes, the combination of growth and attractive valuation at entry support the potential for a multi-bagger
6. Will the stock be covered by the sell-side and will they rate it a buy with a target price above $25?	Yes, JWS (the SPAC) was a $750 million deal backed by billionaire Barry Sternlicht (one of the biggest ever). CANO has a pro-forma EV over $4 billion and pure play comp in OSH that is covered by 12 sell-side analysts. Given the over 50% valuation gap to OSH, and the 11/12 buy ratings that OSH currently has, I think it is likely that CANO will get near universal buy ratings with targets between $25 - $35
7. Is the stock optically cheap on simple metrics?	Yes, the valuation disconnect is obvious. The stock is ~50% cheap to a pure play competitor (which itself is an attractive investment). Bounding the lower end of valuation, a recent IPO of a similar business, (but less attractive compared to CANO), was completed at a valuation premium to the current trading value.

The proceeding memo covers the salient debates and topics of interest regarding JWS/CANO. It is not intended to be exhaustive. The current timeline is for an update S-4 over the next 2-3 weeks, a subsequent shareholder vote and deal close / de-spac sometime in May.

JWS/CANO Trades at >50% discount to OSH…
…CANO and OSH are comps….
…OSH is a buy….
...CANO is buy…

Topic List

- The Reason We are Here: Cano & Other Primary Care Providers are Reducing Costs & Improving Outcomes
- The TAM is MASSIVE & Direct Contracting Will Multiply It
- CANO vs. OSH
- OSH's Valuation
- Sell Side Coverage Expectations for CANO
- Addressing Churn
- Humana: The Biggest Counterparty
- Medicare Fee-For-Service Patients
- De Novo Economics
- De Novo vs. Acquisition vs. MSO and the Question of Execution
- Actual and Projected Financial Performance
- How We Got to SPAC
- SPAC Considerations
- Thoughts on Terminal Value
- Appendix 1: Other Players in the Industry
- Appendix 2: Overview of Direct Contracting

The Reason We are Here: Cano & Other Primary Care Providers are Reducing Costs & Improving Outcomes

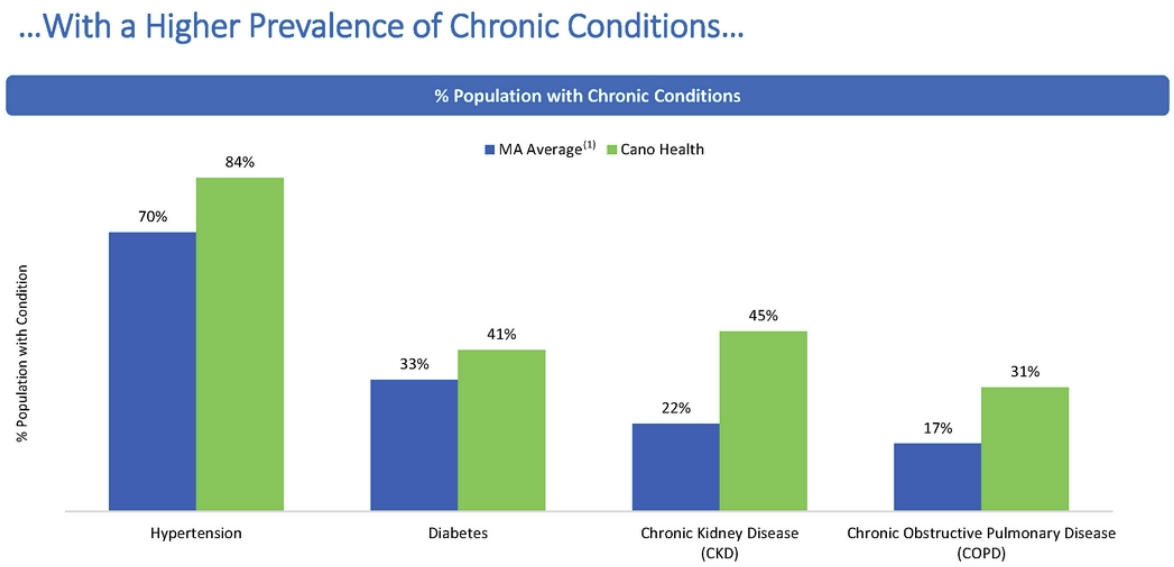
> *Summary Thoughts: Value-Based Primary Care providers are generating superior patient outcomes compared to other models. They entire healthcare industry is expanding further into value-based care relationships and this model has broad bi-partisan support. The superior patient outcomes (shorter stays in hospitals, fewer ER visits, etc) are coming at a lower cost to the overall healthcare system as compared to other care models.*

The new wave of value-based primary care provider, of which CANO is one of many, are part of a growing trend towards value-based care. At the core of this trend is the idea that by compensating primary care differently, we can reduce overall healthcare costs. It is important for this growing industry to show that they are a solution for healthcare payors.

CANO focuses on Medicare patients with multiple chronic conditions. Indeed, when looking at Medicare data (below is from 2017), patients with multiple conditions account for the lion share of costs.

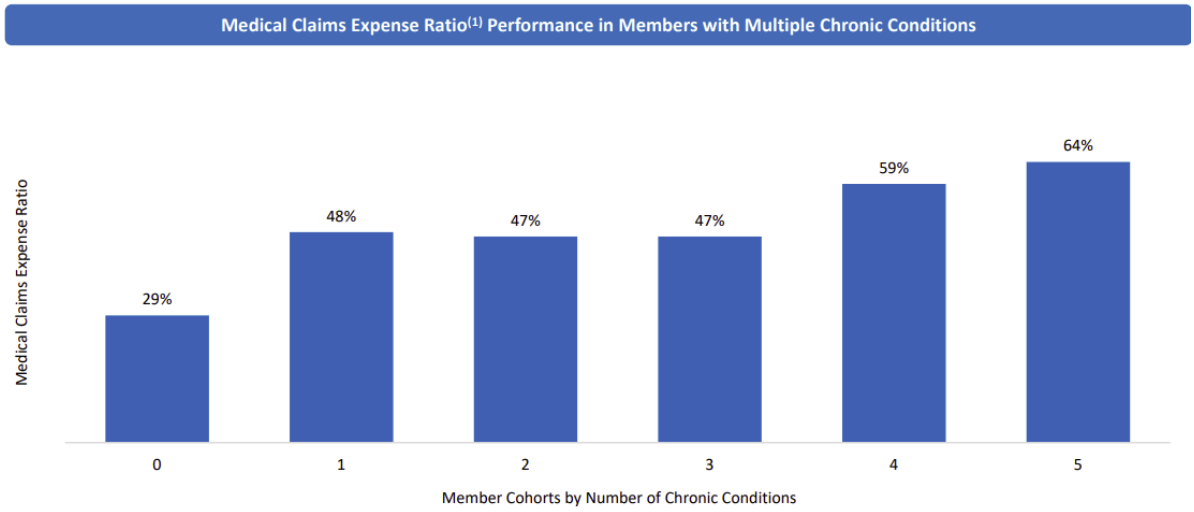
Number of Chronic Conditions	Number of Medicare-Eligibles		Spending*				
	Total People	% of Medicare FFS	Total ($ billions)	% of Medicare FFS	% of Total Medicare	Per Capita	% of Total Medicare
0 to 1	10,940,657	32%	$22	6%	3%	$2,032	17%
2 to 3	9,871,548	29%	$58	17%	8%	$5,906	49%
4 to 5	7,173,483	21%	$83	24%	12%	$11,539	96%
6+	5,740,135	17%	$185	53%	26%	$32,245	**267%**
Total Medicare FFS - Part A & Part B	**33,725,823**	**100%**	**$348**	**100%**	**49%**	**$10,330**	86%
Medicare Advantage	19,789,414		$214		**30%**	$10,792	89%
Medicare - Total	**58,457,244**		**$705**		**100%**	**$12,062**	100%
Medicare Part D (MA-PD + standalone PDP)	42,728,443		$80		11%	$1,865	
Other spending**			$63		9%		

Cano's patients are disproportionately exposed to chronic conditions:



Logically, members with a higher number of chronic conditions have a higher MLR:

Medical Claims Expense Ratios Strong for Members with Multiple Chronic Conditions



Key competitor OSH has similar patient exposures as Cano. Per the OSH 10K:

> *Our patients have complex health needs. As of 2017, the average income of our patient base, as self- reported to us, was approximately $20,700. Approximately 45% of our patients are dual eligible for both Medicare and Medicaid as of the year ended December 31, 2020. Approximately 40% of our patients have a behavioral health diagnosis and approximately 50% struggle with one or more social risk factors like isolation and lack of access to housing and food that are considered social determinants of health. Approximately 86% of our at-risk patients have one or more chronic conditions, with the average at-risk patient having three or more chronic conditions…*

Both Cano and OSH serve members that are dual eligible for both Medicare and Medicaid. 50% of Cano members are dual eligible (with 80% of members from minority groups). OSH is similar, with 45% of members dual eligible. Dual eligible patients have (1) typically more chronic conditions, (2) less stable health care and (3) cost the health care system far more than other patients. From the INNV roadshow:

The "Big Problem": Unsustainable, High Costs in U.S. Healthcare

Medicare and Medicaid spend, on average, 3x more per capita on a dual-eligible senior than a Medicare-only senior

Improved care management of dual-eligible seniors and coordination of Medicare and Medicaid benefits is critical to reducing the rapid growth in government healthcare spending in the United States

[1] 2018 Medicare total enrollment of ~60mm; [2] December 2018 total Medicaid enrollment, excluding CHIP, of ~65mm; [3] Percentages represent InnovAge estimates; dollar amounts estimated based on 2018 Medicare and Medicaid total expenditures of ~$758bn and ~$600bn, respectively

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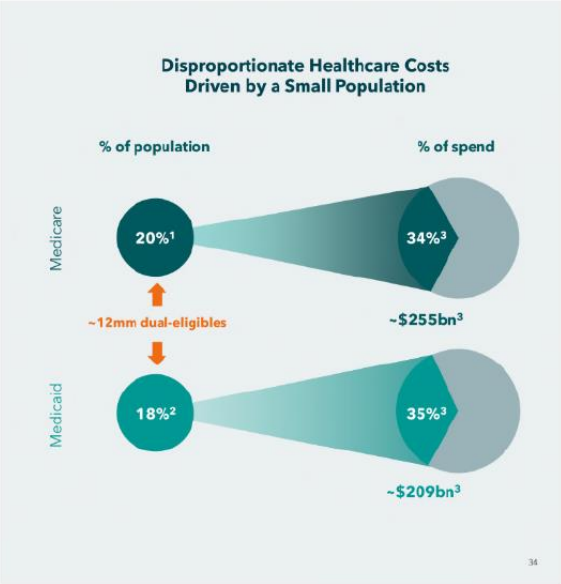
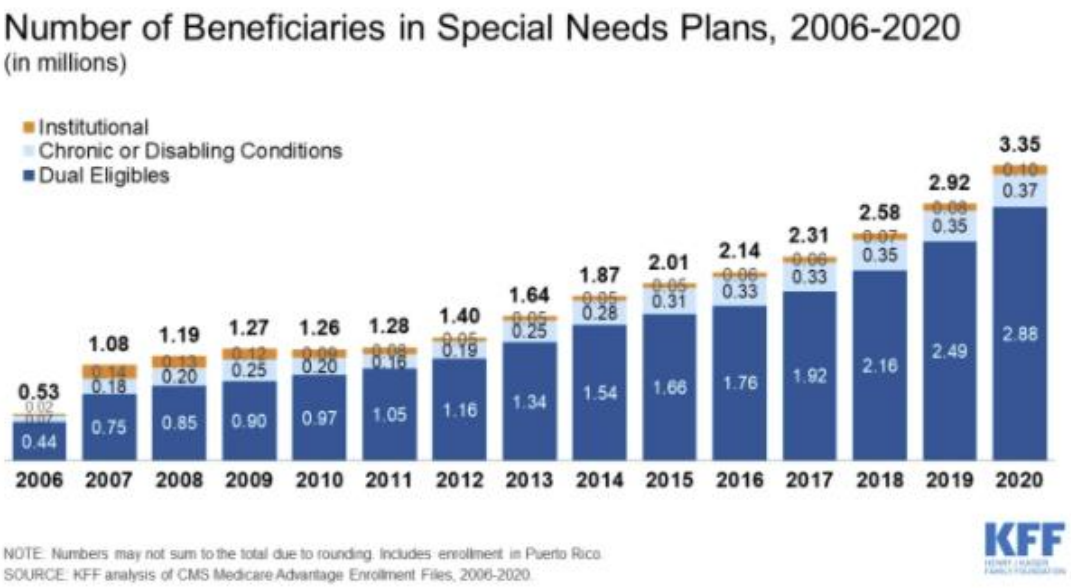


Dual-eligibles are a big opportunity for value-based primary care providers:

- They have a higher risk score for MA, which means the revenue is higher
- They have the biggest potential for improvement as they lack a stable Primary Care relationship and have a higher than average amount of chronic conditions

The Dual-eligible population is also growing faster than other parts of Medicare:



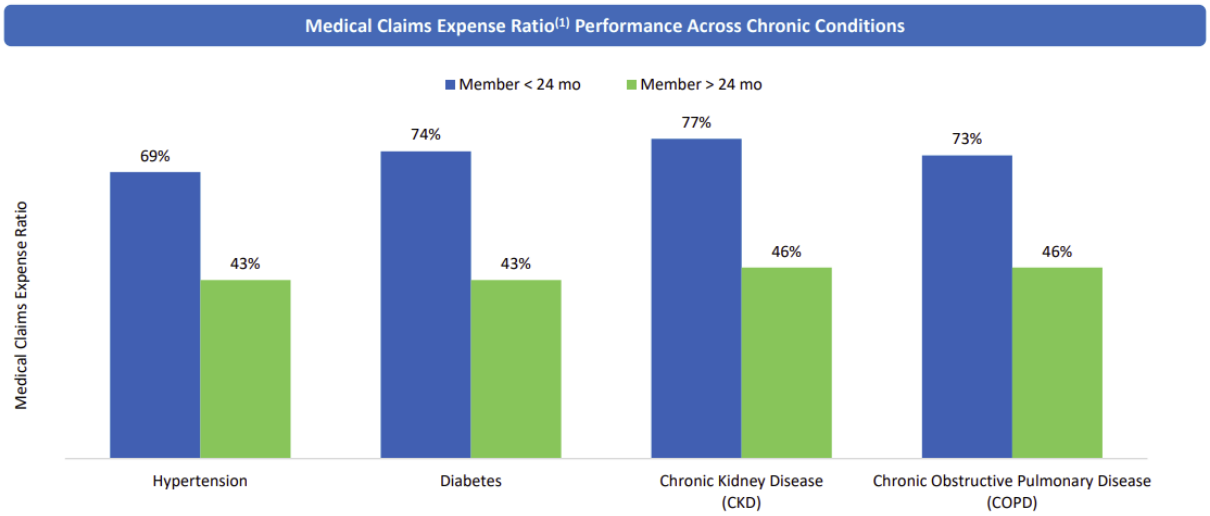
As discussed in the section about churn, the downside with this population is that changes in status lead to more friction with insurance coverage and ultimately higher churn.

The opportunity for Primary Care providers is to improve patient outcomes and lower costs. Legacy Medicare Fee for Service arrangements have done little to improve patient outcomes. By moving to an at risk, capitated model (through Medicare Advantage), primary care providers have shown an ability to both reduce costs and improve patient outcomes. According to an April 2019 report by the Urban Institute:

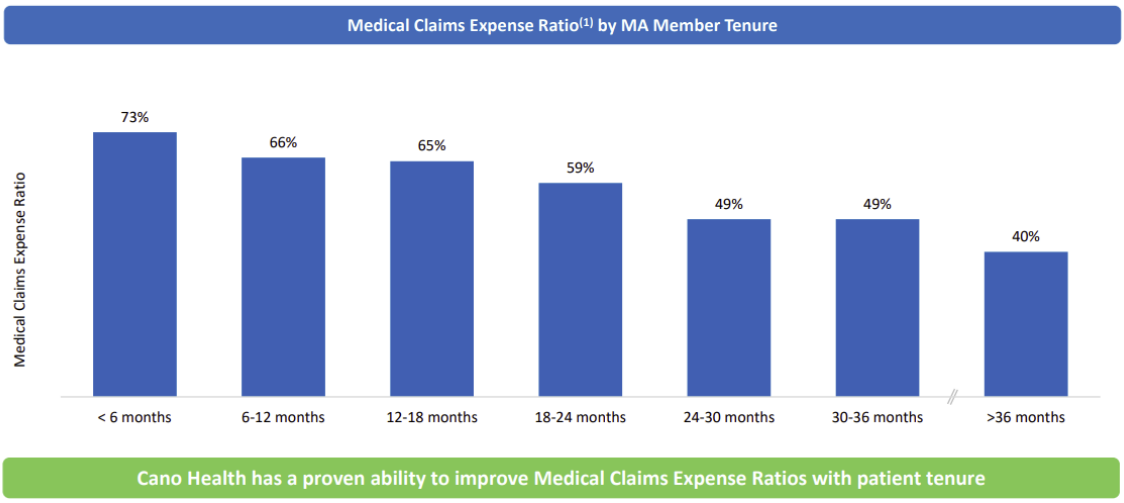
> *Many policymakers believe including private health insurance plans in Medicare has the potential to improve quality, increase beneficiaries' choices, and reduce government spending, among other policy objectives (Berenson and Dowd 2009). But, the federal government has struggled to control MA costs, and in 2009, average payments to MA plans peaked at 114 percent of spending on traditional Medicare (MedPAC 2009a). These overpayments to private plans were partially attributed to the bidding and benchmark process, established in the Medicare Modernization Act of 2003 to stabilize declining plan participation and benefit generosity of private plans in Medicare (Berenson and Dowd 2009; Patel and Guterman 2017; Zarabozo and Harrison 2009).*
>
> *The Affordable Care Act (ACA), enacted in 2010, introduced several changes to the MA payment rate calculation to better align Medicare spending on private plan enrollees with average spending per traditional enrollee. Under the ACA, the Centers for Medicare & Medicaid Services (CMS) sets county-level benchmarks at four levels based on estimated per capita spending in traditional Medicare, where the quartile of counties with the highest per capita traditional Medicare spending is assigned a benchmark of 95 percent of traditional Medicare cost, and the lowest-spending quartile is assigned a benchmark of 115 percent of traditional Medicare costs (Biles et al. 2012). The ACA also lowered the rebate amounts from 75 percent to 50–70 percent of the difference between the benchmark and a plan's bid, depending on the plan's quality ratings, and allowed plans with four-star quality ratings and above to receive both higher benchmarks and rebate percentages (Hayes 2015). Changes introduced under the ACA succeeded in lowering the payments MA plans from an average of 114 percent of traditional Medicare spending per beneficiary in 2009 to an average of 101 percent in 2018 (MedPAC 2009b, 2017)…*
>
> *…Second, the ACA phased in payment cuts over several years, giving plans time to adjust by controlling costs. On average, MA plans reduced their bids from 102 percent of traditional Medicare spending per beneficiary in 2009 to 90 percent in 2018 (Guterman, Skopec, and Zuckerman 2018; MedPAC 2009b, 2017). Contrary to initial fears, MA plans lowered their bids without reducing supplemental benefits or increasing premiums and cost sharing, resulting in relatively stable enrollee access and affordability since ACA implementation (Skopec, Zuckerman, and Aarons, forthcoming; Song and Pelech 2018).*

In terms of patient outcomes, both Cano and OSH tout impressive statistics. CANO shows significant patient improvement over time, which is the name of the game:

… and Improves Medical Claims Expenses with Member Tenure



Cano Health's Medical Claims Expense Ratio Improves with Member Tenure



Similarly, OSH has a significant positive impact on its patients (from prospectus filed 2/11/21):

> *This is evidenced by our strong track record of quality outcomes and patient experience metrics, as evidenced by our Net Promoter Score of 90, and by our patient health metrics, including an approximately 51% reduction in hospital admissions (based on our hospital admission rates per thousand patients of 183 as of March 31, 2020, compared to the Medicare benchmark of 370), 42% reduction in 30-day readmission rates (based on our rate of hospital readmissions within 30 days per thousand patients of 11% as of March 31, 2020, compared to the Medicare benchmark of 19%) and 51% reduction in emergency department visits (based on our rate of emergency department "treat and release" claims per thousand patients of 535 as of December 31, 2019, compared to the Medicare benchmark of 1,091)*

The reason that outcomes are improving is because incentivizing the primary care provider promotes preventive care. The lion share of healthcare spending is related to hospitalization. If you can reduce that, the impacts are enormous. Just 3% of spending is related to primary care (from the OSH 10K):

> *In 2018, over 60% of Medicare expenditures (including both Medicare Part A spend and Medicare Part B institutional spend), or approximately $455 billion, were dedicated to hospitalization, compared to only approximately 3% dedicated to primary care. Compared to a Medicare fee-for-service benchmark, we have been able to drive an approximately 51% reduction in hospital admissions, 42% reduction in 30-day readmission rates and 51% reduction in emergency department visits.*

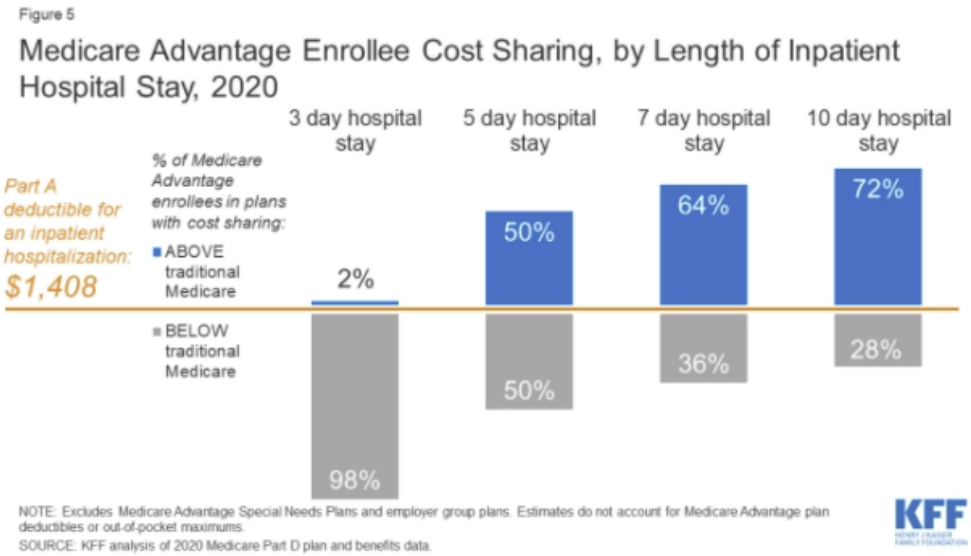
Spending more on primary care REDUCES spending on everything else, namely the really expensive inpatient hospital stays. As Medicare members continue to transition to both Medicare Advantage, and risk based care arrangements in general, total costs should continue to fall, while primary care providers (ie Cano) will win. According to a senior executive at a national primary care company:

> *…If you are on the Fee for Service hamster wheel of 30 patients a day, this is not a hard sell to come over to a value-based provider…*
>
> *…You don't have to do that well on medical costs to do well, because primary care has been so under invested in this country. There is still runway here [to improve outcomes]…*
>
> *…We are in a much better position to influence medical costs, unlike a Humana or another insurance company, because we are the provider…for the longest time, for the Medicare Advantage company, it was about maximizing revenue. What does that mean? It means maximizing these [coding] adjustments…absolutely it is accretive to focus on medical costs…but focusing on medical costs [only] is difficult….*
>
> *Everything seems like 'we [CMS] just want to push people into Medicare Advantage…'*

Below is a side-by-side estimate of the cost to serve a MA vs. FFS patient. Lower hospitalization costs, as well as the cost of Medigap, Part D and Dental / Vision insurance costs are the other drivers.

Annual Spend / Beneficiary	Medicare Advantage	Medicare FFS	Difference Dollar	Difference %
Preventative Services / Tests	$3,811	$3,139	672	21.4%
Inpatient Costs	2,898	3,477	(579)	-16.7%
Outpatient Costs	2,359	2,474	(115)	-4.6%
Durable Medical Equipment	331	227	104	45.8%
Part A Premium	41	41	0	0.0%
Part B Premium	1,754	1,799	(45)	-2.5%
Part C, Medigap, Part D, Dental / Vision, and other	336	1,811	(1,475)	-81.4%
Total Annual Spend	$11,530	$12,968	(1,438)	-11.1%
Annual Spend x Preventative	*7,719*	*9,829*	*(2,110)*	*-21.5%*

Inpatient, or hospitalization costs, are one of the biggest differentiators between the cost of Medicare Advantage and Medicare FFS. This is where the value of preventive care, and closer communication between the physician and the patient can drive better outcomes. For CANO, and other Medicare Advantage focused providers, the potential costs of lengthy patient stays can significantly detract from financial performance (to say nothing of the patient impact):



The TAM is MASSIVE & Direct Contracting Will Multiply It

Summary Thoughts: CANO, and other Value-Based Primary Care Providers, target the Medicare population. The current addressable market is Medicare Advantage members, who represent ~40% of all members or ~25 million people. Traditional Medicare operates in a "Fee-For-Service" construct where providers are only paid for the services they provide and does NOT incentivize providers to invest in preventative care – the anthesis of value-based care. Medicare Advantage is a premium form of Medicare that is administered by health insurance companies that offers a holistic capitated payment model to enable value-based care providers to take risk, and reap the benefit, of the entire cost of patient care- irrespective of whether they provide the service or not. The penetration of Medicare Advantage is increasing, driving Medicare Advantage growth far above the rate of overall Medicare member growth. Additionally, a new program being piloted by CMS (Centers for Medicare and Medicaid) called Direct Contracting will potentially enable ALL Medicare members to enter holistic capitated payment arrangements with their primary care provider.

CANO's potential patients are all Medicare Enrollees. Medicare spending is currently ~$800 billion per year and expected to grow 8% annually to over $1.25 trillion by 2025. Medicare Advantage ("MA"), the faster growing portion of Medicare, accounts for $270 billion of spending and is expected to grow at a 14% CAGR to $590 billion by 2025. According to CMS, at year end, there were ~25 million members enrolled in MA and ~37.7 million members in traditional Medicare:

	2016	2017	2018	2019	2020
Total United States					
Medicare	38,610,384	38,667,830	38,665,082	38,577,012	37,712,482
Medicare Advantage	18,370,800	19,789,414	21,324,800	22,937,498	25,064,153
Total	56,981,184	58,457,244	59,989,883	61,514,510	62,776,635
MA Penetration	32.2%	33.9%	35.5%	37.3%	39.9%
Medicare YoY		0.1%	0.0%	-0.2%	-2.2%
Medicare Advantage YoY		7.7%	7.8%	7.6%	9.3%
Total YoY		2.6%	2.6%	2.5%	2.1%

Penetration of MA has increased over time. It is projected that MA will reach over 50% of all Medicare patients by 2025. On a static basis, this would imply a 6.3 million member increase to the MA population or ~25% of current members. The movement towards MA, and away from traditional Medicare (known as "fee-for-service" or "FFS"), is driven by both cost and customer choice. On the cost side, while MA used to be more expensive, this has declined over time and MA is now cheaper than FFS to payors (ie the government). In terms of choice, MA plans are administered through private insurance companies and tend to offer more options, better service and superior patient outcomes (see next section).

Cano, and its peers, have a near infinite market opportunity as MA expands. Consider the following from OSH's recent Q4 earnings call (note they have just 79 centers currently and are building 40 more in 2021):

Frankly, right now, the limiting factor to our growth is now a market opportunity. We can put an order of magnitude more centers in 2021 and still be scratching the surface of the overall market opportunity. It really comes down to us having the appropriate level of confidence in our ability to execute. And I think we will skew it by what I talked in the call, titrate up the number of centers every year to make sure that everything is going smoothly, and we are continuing to see the same kind of trajectory of improvements of our vintages.

As long as we're seeing that, we'll put up more centers next year and repeat. So again, we're really, really excited about the future opportunity and putting up more centers. That was a pretty easy decision because ***the market can support 10,000 Oak Street centers****. So we are a long way from making a dent in that market, and we feel a huge need to put up more centers because we also feel like the quality of care we are providing is just differentially better. And so we want to bring it to more people.*

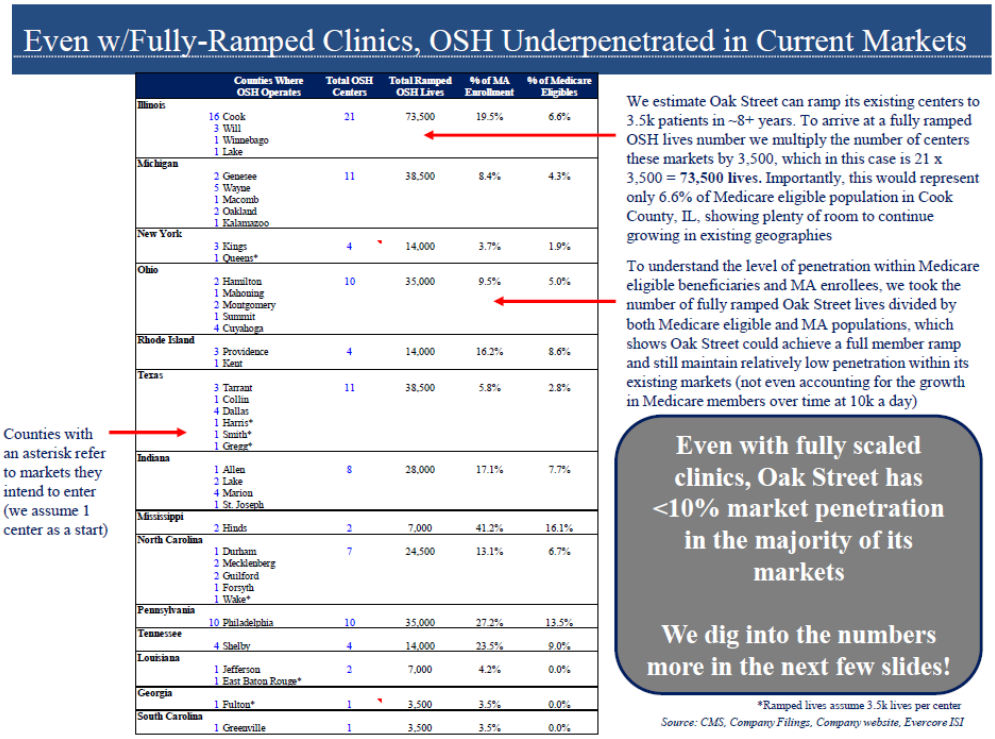
CANO, in its core Florida Market, is barely scratching the surface. In its 5 counties of operation, its members represent 8.2% of MA members and 4.7% of total Medicare (including FFS). When expanding to all of Florida, Cano's members account for 1.6% of total Medicare beneficiaries.

	Cano Medicare Advantage	
Florida		
HUM	54,938	74.4%
ANTM	7,322	9.9%
UNH	4,937	6.7%
BCBS	1,564	2.1%
CNC	1,560	2.1%
AET	1,174	1.6%
All Other	2,334	3.2%
	73,829	

	Core Markets	Total Florida
Market Share		
MA	8.2%	3.3%
Total	4.7%	1.6%

	Medicare	Medicare Advantage	Total Medicare
Core Markets			
Broward	136,915	194,587	331,503
Miami-Dade	138,483	336,921	475,405
Palm Beach	193,983	137,980	331,963
Orange (Orlando)	90,301	102,127	192,428
Hillsborough	112,255	129,845	242,100
	671,937	901,460	1,573,399
All Other	1,735,318	1,366,634	3,101,950
Total Florida	2,407,255	2,268,094	4,675,349

CANO's penetration is more attractive than OSH's in its largest markets. While CANO's core Florida footprint has plenty of room to expand, OSH's existing footprint in IL will eventually account for ~19.5% of the current MA market. However, when adjusting for expansion of MA penetration (partially driven by Direct Contracting), there remains ample white space to grow.



Shift to Value-Based Care

In addition to the ever-increasing penetration of Medicare Advantage, there is also growing shift to "value-based" providers like Cano who receive a fixed / "capitated" per member per month payment ("PMPM").

> *"CMS Primary Cares is a clear effort to shift one quarter of our Medicare population to outcomes-based payments…It's time to dismantle the old broken fee-for-service system and replace it with one that is focused on outcomes and quality." - Director of CMS Innovation Institute*

> *"Cigna's focus on quality and affordability enabled the company to exceed its 50% alternative payment goal, offering more value for our customers' clients health care dollars…Our commitment to value-based care and the alternative payment models is driving better health outcomes, increased affordability and improved patient experience for the people we serve." – Chief Medical Officer at Cigna*

> *"We estimate that at the end of 2020, we will have $75 billion of our payments to care providers tied to value-based care relationships, up from $64 billion in 2017. This shift in how health professionals and payers work together has already begun to reshape systems and business models…" - United Healthcare*

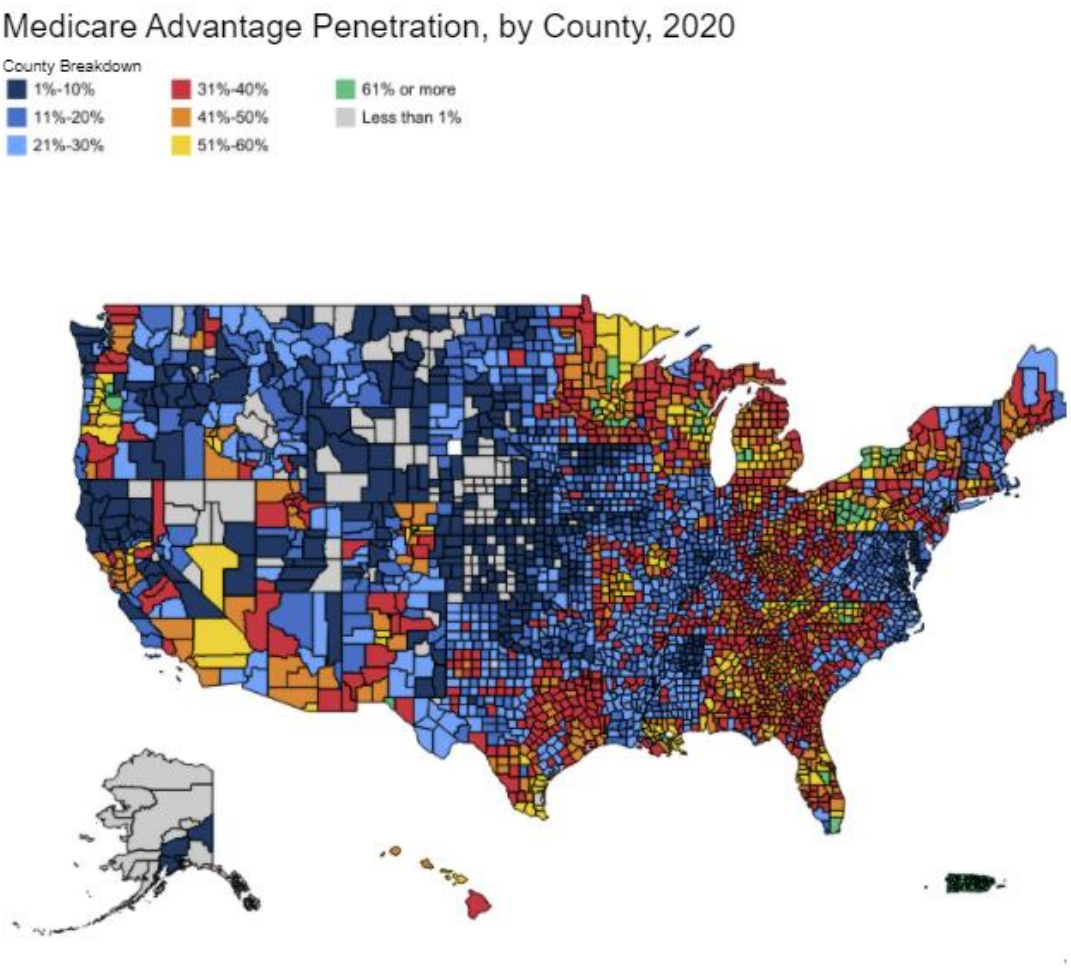
Penetration of these models is still relatively low. Even MA is still over 50% Fee for Service, leaving substantial white space for future growth:

	Commercial	Medicare Advantage	Traditional Medicare	Medicaid	Total
FFS	57%	48%	11%	68%	41%
FFS - Linked to Quality or Value	15%	3%	51%	7%	25%
Upside Only	16%	25%	25%	18%	21%
Capitation	10%	24%	14%	7%	13%

Outside of Medicare there are multiple companies pursing value-based care models. One Medical ("ONEM") is on the comp table for CANO and focuses on affluent commercial members (the antithesis of the CANO/OSH target audience). The stock completed an IPO in January 2020 at $14 per share and currently trades at $39 (9.5x revenue, further supporting the OSH and CANO valuations).

Medicare Advantage Penetration is Increasing

It is estimated that MA will represent ~50% of all Medicare members by 2025. Penetration varies significantly by county, but is generally higher in more dense areas:



Looking at individual states highlights how strong the trend to MA is:

- Puerto Rico has almost no growth in total Medicare Members (owing to the near default on the Island, as well as the hurricane). Even with extremely high penetration of MA, it is still showing 1.5% annual growth in MA members
- New York, with about average MA penetration is showing 6.0% growth in MA members, even as its total population barely grows
- Nebraska, shown as a generic example of what many similar states look like, has the twin benefit of low existing penetration and moderate population growth. Combined, these two factors are leading to a 15.5% annual CAGR for MA membership

	2016	2017	2018	2019	2020	CAGR
Puerto Rico						
Medicare	178,945	171,923	168,267	160,876	149,174	-4.4%
Medicare Advantage	567,328	562,199	573,014	588,996	601,290	1.5%
Total	746,274	734,121	741,280	749,872	750,464	0.1%
MA Penetration	76.0%	76.6%	77.3%	78.5%	80.1%	
Medicare YoY		-3.9%	-2.1%	-4.4%	-7.3%	
Medicare Advantage YoY		-0.9%	1.9%	2.8%	2.1%	
Total YoY		-1.6%	1.0%	1.2%	0.1%	
New York						
Medicare	2,139,045	2,126,620	2,120,188	2,118,566	2,064,676	-0.9%
Medicare Advantage	1,270,989	1,355,601	1,438,985	1,511,057	1,603,066	6.0%
Total	3,410,034	3,482,221	3,559,173	3,629,623	3,667,742	1.8%
MA Penetration	37.3%	38.9%	40.4%	41.6%	43.7%	
Medicare YoY		-0.6%	-0.3%	-0.1%	-2.5%	
Medicare Advantage YoY		6.7%	6.2%	5.0%	6.1%	
Total YoY		2.1%	2.2%	2.0%	1.1%	
Nebraska						
Medicare	281,922	286,449	288,294	288,127	282,253	0.0%
Medicare Advantage	40,029	43,031	49,715	58,022	71,197	15.5%
Total	321,951	329,480	338,009	346,150	353,450	2.4%
MA Penetration	12.4%	13.1%	14.7%	16.8%	20.1%	
Medicare YoY		1.6%	0.6%	-0.1%	-2.0%	
Medicare Advantage YoY		7.5%	15.5%	16.7%	22.7%	
Total YoY		2.3%	2.6%	2.4%	2.1%	

Direct Contracting is Rocket Fuel for the TAM

Summary Takeaway: Direct Contracting is one of the most important things to understand for the bull thesis on CANO and OSH. At the most basic level, it will enable all Medicare members to be potential patients for value-based care providers (who currently only make money on MA patients). Prior to Direct Contracting, the addressable market for Value-Based Primary Care Providers like CANO was only the 40% of the Medicare Population enrolled in Medicare Advantage. With Direct Contracting, the addressable market expands to 100% of all Medicare members…currently there are 25 million members in Medicare Advantage as opposed to 62.7 million total Medicare members

	2016	2017	2018	2019	2020
Total United States					
Medicare	38,610,384	38,667,830	38,665,082	38,577,012	37,712,482
Medicare Advantage	18,370,800	19,789,414	21,324,800	22,937,498	25,064,153
Total	56,981,184	58,457,244	59,989,883	61,514,510	62,776,635
MA Penetration	32.2%	33.9%	35.5%	37.3%	39.9%
Medicare YoY		0.1%	0.0%	-0.2%	-2.2%
Medicare Advantage YoY		7.7%	7.8%	7.6%	9.3%
Total YoY		2.6%	2.6%	2.5%	2.1%

Traditional Medicare Advantage plans are administered by insurance companies, but serve traditional Medicare beneficiaries. In Direct Contracting, Medicare will "directly contract" with care providers and eliminate the insurance companies in the middle.

> Medicare Advantage: CMS (Centers for Medicare and Medicaid) provides reimbursement to health insurance plans based on Risk Adjustment Scores ("RAF"). The health plans contract with medical providers and administer the plans on behalf of patients. In this model, CANO is paid by the health insurance plan.
>
> Direct Contracting: CMS contracts directly with the medical providers. In this model, CANO is paid by CMS

CANO is one of 41 providers selected to take part in CMS's Direct Contracting pilot. Direct Contracting ("DC") will offer providers contracts analogous to capitated MA contracts. DC goes live April 1st and CANO expects ~11,000 new members immediately. This ~$130 million of annual revenue is not in CANO's guidance. The total opportunity is far larger than the 2021 impact, however. Overtime, DC is expected to accelerate the shift from traditional Medicare to MA, per a senior industry executive:

> …I think for those not comfortable with MA, here is a nice middle of the road option and over time, it all shifts to MA…oh yeah, CMS would be happy if everyone moved from FFS to MA…

Another executive went further:

> *Yes, [direct contracting is a straw man to get more people enrolled in MA], direct contracting, at least from the perspective of risk bearing providers…the strategy is all the same. Let's juice up the economics for the Medicare Fee for Service population- which we were either "A" not seeing from an economics perspective, or "B" we are losing money on because our model was predicated on getting these Fee for Service patients into a Medicare advantage program. So it's less of a straw man and more of a life line…there is this nice little bridge where we can now make the economics of the FFS realm, which were largely ignored as a loss leader…. now it can make a little more sense for us to juice up the economics of a particular center [ie encouraging more center expansion and more penetration of risk based primary care providers]… CMS would love eventually to just have Medicare Advantage for All…and call it a day. Direct contracting is baby steps to that… Everything seems like 'we [CMS] just wants to push people into Medicare Advantage…*

From the Q3 2020 OSH earnings call. The CEO is noting that a lot of members on traditional Medicare are uneducated on their options and the mere process of enrolling members in Direct Contracting will lead to a conversation that may result in that member choosing Medicare Advantage (some of this is technical on the nuances of Direct Contracting which I cover in the appendix):

> *JPM Analyst: Okay. My follow-up would be what's the pitch to a senior for voluntary enrollment? So like what would be the example of a senior where MA with a supplemental benefit offering isn't a better option? Or is voluntary enrollment primarily going to be for seniors who, for whatever reason, just aren't willing to go into a private plan, don't want to do MA and then this is something that you're offering to them? But even as you do, what's the pitch to get them to sign up for it?*
>
> *OSH CEO: Yes. One thing to be clear about is I don't look at this as a trade-off. And operationally how we put these products into place, it's not that we're staying to someone, "Okay, here's Medicare Advantage. You can do that. This is how this works. And here's voluntary alignment for Direct Contracting. You can do that if this is what you want." Like that is 100% not the way the conversation goes. When we're talking about Direct Contracting, regardless of whether AEP, SEP, one of the kind of years, when a patient on traditional Medicare walks through the door who has not signed the paperwork, we're talking about it, right? And we're talking about it kind of when they're checking in and say, "Hey, here is a new government program we're part of. We're your PCP. And we'd like you to sign this form that says, 'Yes, Oak Street Health is my primary care provider,'" right? That's what the form says. Is Oak Street your primary care doctor? And there's no downside for the patients who sign that, right? They can change their primary care doctor the next day. They can still keep Oak Street as their primary care doctor and go see a different doctor if they want to. They don't need prior authorization. There's no network, right? There's zero downside for patients to sign that form. And so what our goal is and what we're talking to patients about is to make sure they understand that. Like this will help us get more data on you. This will help us take better care of you. But there's no limitation. You have to sign this form. The same patient may sign the form when they walk in the door and they check in. And then later in the visit, they may hear about Medicare Advantage and decide they want to explore that option and meet with their broker and sign up for Medicare Advantage, right? And the Medicare Advantage conversation is all about a trade-off between benefits. "Here's what I have on traditional Medicare. Here's what Medicare Advantage is going to offer me. What's right for me?" The Direct Contracting alignment is just something that you should do, right? And if the alignment -- individual during the visit signs for Direct Contracting and then later in the day she decides Medicare Advantage, so just join Medicare Advantage and the alignment will be-- won't matter, right? So I want to make sure that's very clear. Like when we think about this, it's not a trade-off. Our economics don't play into this at all. It's really all about everyone who is on traditional Medicare should sign the alignment form because there's no downside to them, and obviously, that means we can take better care of them. And then on the MA front, we got -- we want to educate our patients so they make the right decisions for them.*

Whether or not members stay in DC, or transition to MA, the sheer scale of the potential upside from the program is massive. In CANO's core Florida markets (which isn't even all of Florida), the opportunity is ~670k current Medicare members transitioning to a capitated payment model at $1,350 per month, or $11 billion per year. Nationwide, the potential is ~37.7 million members, or over $600 billion per year in capitated revenue. Given the low penetration of value-based care, and the even lower penetration of CANO / OSH / Other Value-Based Primary Care Providers, there is ample space for a lot of winners. From the CANO S-4:

> *According to the industry group HCP-LAN, a shift toward value-based care for Medicare patients (e.g., direct contracting) may increase the share of Medicare value-based payments from 30% of total payments in 2020 to 100% by 2025, tripling the current value-based Medicare market to $800 billion.*

Potential for Lowering the Age of Eligibility for Medicare

While not in the numbers and a low probability event, Biden did campaign on lowering the age for Medicare eligibility to 50. This would massively increase the TAM.

CANO vs. OSH

Summary Thoughts: CANO is cheaper than OSH. CANO and OSH are near perfect comps. OSH is a buy. The ~50% valuation disparity between the two companies is unlikely to be sustainable in the public markets where a 20-30% disparity will inevitably lead to activist / suggestive pressure.

JWS is unique among SPACs in that it has a near perfect comparable public company to benchmark against. Both companies are the in the same business, have similar revenue, have the same largest customer (Humana), are exposed to the same macro trends, and have younger / dynamic CEOs. Indeed, looking at the financials, it is hard to distinguish which is which:

	OSH						Cano / JWS					
	2018	2019	2020	2021	2022	CAGR	2018	2019	2020	2021	2022	CAGR
FFS Patients	20	31	33									
At Risk Patients	30	48	65	106	150	50.1%	25	42	106	158	230	74.2%
PMPM	*$870*	*$931*	*$1,100*	*$994*	*$1,036*		*$770*	*$722*	*$655*	*$766*	*$808*	
Capitated Revenue	310	540	851	1,263	1,871	56.8%						
Other Revenue	8	17	31	33	40	48.0%						
Total Revenue	318	557	883	1,296	1,911	56.6%	231	364	833	1,453	2,230	76.3%
Medical Claims Expense	(228)	(386)	(618)	(915)	(1,306)	54.8%	(154)	(241)	(570)	(1,028)	(1,619)	80.1%
MLR	*-73.5%*	*-71.5%*	*-72.6%*	*-72.5%*	*-69.8%*		*-66.7%*	*-66.2%*	*-68.4%*	*-70.8%*	*-72.6%*	
Other Expenses	(162)	(266)	(357)	(571)	(759)	47.1%	(62)	(96)	(193)	(330)	(476)	66.5%
EBITDA	(72)	(95)	(93)	(191)	(154)	21.0%	15	27	70	95	135	73.2%
Margin	*-22.6%*	*-17.1%*	*-10.5%*	*-14.7%*	*-8.1%*		*6.5%*	*7.4%*	*8.4%*	*6.5%*	*6.1%*	

CANO has historically experienced a higher growth rate of revenue and has grown EBITDA. While a large portion of the growth is acquisition driven vs. De Novo, to date, this strategy has been more successful. The debate that will rage over time is the relative premium vs. discount of the two companies against each other. The current discount is substantial. JWS bought CANO at the same valuation as the OSH IPO. The day 1 closing price of OSH implies a CANO price of ~$22 per share. The current trading range of OSH justifies, at equivalent multiples, a $28 - $32 trading range.

	IPO				IPO+1			Current Trading Range					High Tgt
OSH													
Price	20	25	30	35	40	45	50	55	60	65	70	75	80
Shares	250	250	250	250	250	250	250	250	250	250	250	250	250
	5,000	6,250	7,500	8,750	10,000	11,250	12,500	13,750	15,000	16,250	17,500	18,750	20,000
Net Debt	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)
TEV	4,800	6,050	7,300	8,550	9,800	11,050	12,300	13,550	14,800	16,050	17,300	18,550	19,800
Revenue													
2020	883												
2021	1,296	47%											
2022	1,911	47%	116%										
2023	2,988	56%	131%	238%									
Multiple													
2020	5.4x	6.9x	8.3x	9.7x	11.1x	12.5x	13.9x	15.3x	16.8x	18.2x	19.6x	21.0x	22.4x
2021	3.7x	4.7x	5.6x	6.6x	7.6x	8.5x	9.5x	10.5x	11.4x	12.4x	13.3x	14.3x	15.3x
2022	2.5x	3.2x	3.8x	4.5x	5.1x	5.8x	6.4x	7.1x	7.7x	8.4x	9.1x	9.7x	10.4x
2023	1.6x	2.0x	2.4x	2.9x	3.3x	3.7x	4.1x	4.5x	5.0x	5.4x	5.8x	6.2x	6.6x

JWS/CANO													
Price	10	12	14	16	18	20	22	24	26	28	30	32	45
Shares	470	470	476	479	482	484	486	487	489	490	491	491	495
Shares	470	470	470	470	470	470	470	470	470	470	470	470	470
Warrants			6.0	9.4	12.1	14.2	16.0	17.4	18.7	19.7	20.7	21.5	24.9
	4,700	5,640	6,664	7,671	8,678	9,685	10,692	11,699	12,706	13,713	14,720	15,727	22,272
Net Debt	30	30	30	30	30	30	30	30	30	30	30	30	30
TEV	4,730	5,670	6,694	7,701	8,708	9,715	10,722	11,729	12,736	13,743	14,750	15,757	22,302
Revenue													
2020	833												
2021	1,453	74%											
2022	2,230	53%	168%										
2023	3,079	38%	112%	270%									
Multiple													
2020	5.7x	6.8x	8.0x	9.2x	10.5x	11.7x	12.9x	14.1x	15.3x	16.5x	17.7x	18.9x	26.8x
2021	3.3x	3.9x	4.6x	5.3x	6.0x	6.7x	7.4x	8.1x	8.8x	9.5x	10.2x	10.8x	15.3x
2022	2.1x	2.5x	3.0x	3.5x	3.9x	4.4x	4.8x	5.3x	5.7x	6.2x	6.6x	7.1x	10.0x
2023	1.5x	1.8x	2.2x	2.5x	2.8x	3.2x	3.5x	3.8x	4.1x	4.5x	4.8x	5.1x	7.2x

While the consensus, from my research, is that CANO will trade at a 10-20% discount to OSH, I do not believe it is a certainty that this discount will persist over time. Ultimately, execution, growth and profitability will determine which company garners the premium valuation. This can be translated into the consensus estimates for OSH to achieve 56% growth in 2023, while CANO is only budgeting 38% growth. It is notable that CANO's projections exclude Direct Contracting (more on this later), and the street estimates may well in fact be higher. CANO's growth plan also includes M&A, while OSH's does not. The key sources of differentiation:

	CANO	OSH	Comment
Geography	Florida, Puerto Rico, Texas, Nevada, California	Illinois, Michigan, Pennsylvania, Ohio, Texas, Indiana, Others	Advantage CANO
Geographic Concentration	80-90% of revenue is Florida	Overweight Illinois but diversified	Advantage OSH
Market Niche	Significant expertise with native Spanish speakers	None	Advantage CANO
Uniformity	Centers are a blend of size, heritage, MSO vs. Owned and HUM affiliated	Centers are generally uniform. A significant minority are HUM affiliated	Advantage OSH
Management	Doctor / Entrepreneur	Consultant / Harvard Law Grad	Slight Advantage OSH
Fee-For-Service Exposure	Negligible	~1/3rd of Patients	Advantage CANO
Financial Sponsor	InTandem, a Health Care Specialist with Operating Experience	General Atlantic, a growth equity investor	Slight Advantage CANO
Growth Strategy	De Novo, M&A, MSO	De Novo Only	Advantage CANO
Capital Structure	Net Cash	Net Cash + Mega Convert	Slight Advantage OSH
Cash Flow	Positive EBITDA	Negative EBITDA	Advantage CANO
Revenue Mix / Payor Concentration	MA, Medicaid, MSO HUM largest customer	MA HUM largest customer	Slight Advantage OSH
Stock Liquidity	30 Day Trailing Volume is ~$14.0 million / 1.0 mm shares per day. The float will double with the PIPE unlock at deal close	30 Day Trailing Volume is ~$111.6 million / 1.97 mm shares per day. The float continues to increase as the sponsor exits	Slight Advantage OSH. Earlier in the year, JWS/CANO was more liquid. CANO liquidity will increase post de-SPAC

Geography and Geographic Concentration

> *One of the biggest pushbacks on CANO is that they are a "one trick pony" in South Florida. There are a lot of questions about whether CANO can replicate its success outside of its core South Florida market. CANO's recent success in Tampa (see section on growth) partially answers this. While high concentration in South Florida is not strange for a Medicare focused health care company, generally the market prefers more diversification. In 2019 it entered Puerto Rico as Humana's partner. In 2020 it signed deals to expand in Texas and Nevada with Humana. All else equal, the geographic comparisons between CANO and OSH can be described as: (1) South Florida is one of the best markets (good for CANO), while (2) OSH is both more diversified and (3) has shown better success at entering new markets – in terms of number of markets.*

Geographic exposure, and concentration varies significantly across the public (JWS/CANO, OSH) and private players in the space. CANO has the most concentration among the major players. With that said, they are concentrated in one of the best places, Florida. The best markets for the value based primary care model have: (1) A high number of Medicare Advantage members and (2) A high number of D-SNP / Dual Eligible Medicare / Medicaid members. D-SNP / Dual Eligible members are beneficial as they have the most upside to improve care (see section for further discussion).

Having a higher degree of Medicare Advantage penetration cuts both ways, but is generally positive. Lower penetrated markets will have a larger growth runway in theory. You need a threshold level of existing penetration to reach capacity at the center level. Given the low penetration of value-based care, it is not likely that Medicare Advantage penetration rates will matter (so long as the absolute level of members is high enough), in the near term.

Humana's market exposure is a key determinant for most value based primary care providers. UNH is the #1 Medicare Advantage player and they are moving towards vertically integrating. Humana is a leading partner for most of the players in the space. For geographies where Humana has a minimal market share (ie California and New York), the issue is that the primary care provider has to "win" twice: (1) get the patient to switch away from UNH and (2) to your facility. (see later section for a description of the other players)

	State % of MA	State % of D-SNP	MA Ptration	HUM Share	CANO	OSH	PIPC (HUM)	WellMed (UNH)	Village MD	Iora Health	ChenMed
1 CA	11.9%	13.3%	45%	3%	X						
2 NY	6.6%	8.4%	44%	5%		X					
3 FL	9.3%	7.8%	49%	32%	X			X	X		X
4 TX	7.5%	6.5%	43%	30%	X	X	X	X	X	X	
5 PA	5.1%	4.2%	45%	6%		X					X
6 OH	4.5%	3.4%	46%	15%		X					X
7 IL	2.8%	3.4%	30%	25%		X			X		X
8 GA	3.1%	3.1%	43%	25%		X			X	X	X
9 NC	3.4%	3.0%	41%	23%		X	X			X	
10 MI	4.1%	2.9%	48%	10%		X			X		
11 MA	1.5%	2.9%	27%	0%						X	
12 TN	2.4%	2.4%	43%	24%		X					X
13 AZ	2.4%	2.1%	43%	17%					X	X	
14 NJ	2.2%	2.0%	32%	1%							
15 LA	1.5%	2.0%	42%	52%		X	X				X
16 IN	1.9%	2.0%	36%	29%		X			X		
17 AL	2.0%	2.0%	46%	31%							
18 VA	1.6%	1.8%	25%	40%							X
19 WA	2.1%	1.8%	37%	12%						X	
20 CT	1.3%	1.7%	45%	0%						X	
21 MO	2.0%	1.7%	40%	15%			X				X
22 KY	1.5%	1.6%	39%	51%					X		X
23 WI	2.3%	1.6%	46%	12%							
24 SC	1.5%	1.5%	33%	33%		X	X				
25 MS	0.6%	1.5%	24%	57%		X					
36 NV	0.9%	0.7%	40%	30%	X						
					4	13	5	2	8	7	10

Market Niche

CANO is significantly exposed to the Hispanic population. 85% of the employees are bilingual and 80% of members are minorities. CANO advertises on Telemundo. Most of the largest states for Medicare have substantial minority, Spanish speaking populations. There is every indication that CANO is Humana's core partner for these members. CANO is HUM's exclusive partner in Puerto Rico. CANO is opening ~50 Humana partnered facilities in Las Vegas, San Antonio, El Paso and Corpus Christi…all places with a large population in CANO's Hispanic sweet spot. As with geography, there are questions as to whether CANO can grow outside of its core Hispanic focus.

Uniformity

CANO today is a mix of acquired and De Novo facilities. Oak Street is all De Novo and largely uniform. Uniformity is preferred as, especially as these business scale; it leads to a more consistent patient experience. While these businesses all carry stop loss insurance, the nature of taking all the risk on cost of care means that spikes in MLR are a risk.

Additionally, CANO has a meaningful MSO footprint (in the SPAC deal slides they listed ~18% of EBITDA coming from MSO vs. 82% coming from owned clinics). In the MSO model, or Managed Service Organization, CANO has less control at the clinic level than they would in an owned facility. Offsetting the lack of control is that CANO is not responsible for any capital costs. Most MSO affiliates are smaller single doctor clinics that lack scale and benefit from partnering from a larger network like CANO. For a further discussion on MSO vs. De Novo, see section: "De Novo vs. Acquisition vs. MSO and the Question of Execution."

Management

Both CANO and OSH are lead by dynamic, late 30s CEOs. OSH's CEO has a consulting background and graduated from Harvard Law school. He has established credibility with the street as both a great operator as well as a buttoned up and polished executive. CANO's CEO is a dynamic entrepreneur and charismatic leader. He is yet to establish the credibility that OSH's CEO has.

While both management teams appear strong, many in the industry are skeptical. Per an executive at a large private competitor:

> *You need a management team that gets care and can scale [the business]. I just haven't seen many teams that can do both…a significant portion of this industry is managed by not capable people. The two guys that should be in the big leagues [Cano and Oak Street]… it is not clear that 'in another sport' they would be in the big leagues…but that's all you got….a big portion of this industry uses paper charts and fax machines, it is surprisingly antiquated….if it wasn't for the growth you were underwriting, I would be less concerned [about management quality]…*

Another executive was more concise:

> *HCA is head and shoulders above everyone in hospitals. In primary care there is no one like an HCA that is head and shoulders better…*

Fee-For-Service Exposure

See section later in the memo. This is negative of OSH.

Financial Sponsor

CANO's financial backers stand out not just as compared to OSH, but as compared to almost any sponsor backed IPO. InTandem Capital Partners is little known outside of Health Care but is exactly who you want behind a transformational growth asset like CANO. Its two founders, Elliot Cooperstone and Bob Patricelli, are seasoned executives in healthcare that have run companies:

- Elliot Cooperstone: Former CEO of Prodigy Health, which was a health plan administrator for ~600k members. Elliot lead an acquisition fueled growth strategy and eventually sold the business to Aetna ("AET") for ~$600 million in 2011.
- Bob Patricelli: From EVP of Cigna ("CI"), former CEO of Value Health and Evolution Benefits

InTandem merged their own primary care business with CANO in 2017 and has been instrumental in growing the company. InTandem will retain a large stake in the company and have board representation.

OSH's backers are General Atlantic and Newlight Capital Partners. Both are well regarded firms.

Barry Sternlicht is the SPAC sponsor for JWS. He has an impeccable reputation in the investment industry. JWS was his first SPAC and he has since raised two more. Barry is investing $50 million of his own capital in the concurrent PIPE. Other members of the SPAC sponsor are Doug Ostrover (the "O" in GSO who now runs Owl Rock) and Joe Dowling (former CIO of Brown Endowment now at Blackstone). This is a premier SPAC sponsor.

Growth Strategy

See section later in the memo. This is a key debate as OSH only does De Novo while CANO has a three pronged approach to growth with De Novo, MSO and M&A.

Revenue Mix

OSH has a slightly cleaner revenue mix as compared to OSH. CANO generates revenue from Medicare Advantage, Medicaid Capitated and MSO affiliates. OSH almost exclusively generates revenue from Medicare Advantage. Both have substantial payor concentration with Humana. OSH is moving further away from HUM by opening independent centers. CANO is increasing their exposure to HUM by opening centers in Nevada and Texas that are exclusively for HUM members. Being exclusive with a single insurance company has the potential to increase patient churn (see section).

	CANO		OSH	
Revenue Source				
Capitated	796	83.2%	834	94.5%
Medicare Capitated	124	12.9%	0	0.0%
Fee-for-service	11	1.2%	5	0.6%
Pharmacy / Part D	23	2.4%	17	1.9%
Other	3	0.3%	26	3.0%
	957		883	

	CANO		OSH
Members		Revenue	
HUM	54%	HUM	45%
AET	15%	CNC	15%
UNH	5%	CI	11%
FL ACA	10%	Other	29%
Other	15%		

OSH's Valuation

Summary Thoughts: OSH's valuation is a key risk to CANO. Recent milestones such as secondary stock sales, a large convertible bond issuance and increasing sell-side price expectations suggest that OSH's stock is likely to maintain its valuation in the near term.

The most straight forward case for JWS/CANO is the large valuation gap to where OSH trades. The private equity community (see section on deal background, at least two private equity firms made formal bids for CANO before the SPAC merger was announced), while positive on CANO, could not wrap their heads around the valuation of OSH. Indeed, OSH's own management and financial sponsors were surprised with the reception of its IPO, having completed two funding rounds in 2018 at a ~$2 per share valuation. In many conversations, there has been a healthy skepticism with the sustainability of OSH's valuation, and an unwillingness of private equity to underwrite it. In the end, despite CANO being roughly the same size as OSH, the private equity firms were reportedly anchored around $2 billion for CANO / 20x EBITDA vs. the SPAC transaction at $4 billion and OSH (which lacks EBITDA) at ~$12 billion.

At the time of the private equity process, and the SPAC merger, OSH's valuation was far from established. OSH's August 2020 IPO had been a large success, but the float was insignificant, and it was unclear what would happen as more shares unlocked. After the announcement of the JWS/CANO merger, OSH completed the first of two secondary offerings of sponsor shares. The first offering occurred in December (they broke the 6 month lockup early due to demand), and priced at $46 vs. the IPO price from August of $21. In February they did another secondary at a price of $56. In March 2021, OSH completed an $800 million convertible bond offering with a 0% interest rate and a conversion price of $79.16. Trading over $126 million per day of volume in March, it is increasing difficult to argue that the OSH valuation isn't "real." At the same time, there is every indication that the uncertainty of the sustainability of OSH's valuation was factored into the transaction price for CANO. JWS paid the "OSH IPO valuation" for CANO (ie OSH at $21), just as it was becoming more clear that the public market price for OSH ($50+) was the "real" price.

		Shares	Price	Gross Proceeds	Public Float Shares	Public Float Value	Notes
2018	Apr	10.9	$4.02	44			Funding Round
2018	Sep	12.4	$4.02	50			Funding Round (HUM)
2020	Aug	18.0	$21.00	377	18.0	377	IPO
2020	Dec	6.5	$46.00	298	24.4	1,125	Secondary
2021	Feb	12.3	$56.00	691	36.8	2,060	Secondary

		Face	Rate	Maturity	Convert Premium	Convert Price	
2021	Mar	800	0%	2026	42.5%	$79.16	Convertible Bond

		Average Volume Shares	Average Volume Value
2021	Mar	2.31	126
2021	Feb	1.24	73
2021	Jan	0.46	25
2020	Dec	0.52	29
2020	Nov	0.24	12
2020	Oct	0.28	14
2020	Sep	0.48	21

The sell side is bullish on OSH with 11 buys and one hold. The average target price is $69.50 per share. Interestingly, the "bull case" price targets are substantially higher. Consider Morgan Stanley, in a 3/11/21 note that raised their price target from $73 in February to $79 in March (they initiated last year at $50). Their current bull case is $209 per share:

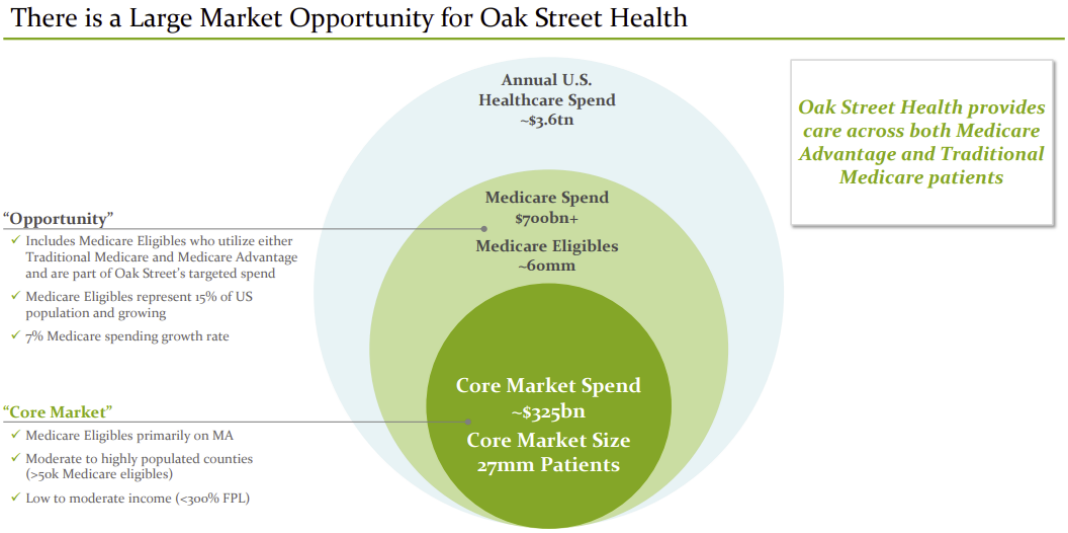
17.2x 2022 EV/rev. Our bull case valuation applies a 0.21x EV/Rev/Growth ratio to our bull case 2020-2022 growth assumption of 81.8% to arrive at a 17.2x EV/Rev multiple. Our bull case captures revenue upside from the Direct Contracting opportunity and new centers.

While their bear case is $30 (would imply ~$17 per share for JWS/CANO at 2022 EV/Revenue multiple parity):

5.7x 2022 EV/rev. Our bear case valuation applies a multiple of 5.7x on our 2022 bear case revenue estimate. This multiple is at the low-end of our digital healthcare comps set. We assume penetration into its existing markets slows, driving <30% revenue growth in 2021 and 2022.

The performance of OSH to date has more than met the hype. A sell-side analyst at a bulge bracket firm described the frenzy on OSH's IPO as "the most interest I have seen in an IPO in my space in at least five years." A sell-side analyst at a research boutique noted "growth is king and this is one of the best growth stories I have ever seen."

OSH identifies their market opportunity as over 10,000 medical centers (they had 79 centers at year end) and terminal margins of ~20%. With 2021 estimate revenue of $1.3 billion, they believe the market size is orders of magnitude larger.



The $800 million OSH Convert

As mentioned, on 3/16, OSH priced an upsized $800 million convertible bond offering. The bond matures in 5 years, has a 0% interest rate and a conversion price 42.5% above the stock price at issuance (ie $79.16 per share, which is ~$45 on JWS on a multiple parity basis). The deal was upsized from $750 million at launch. The issuance of the convert is a clear positive for the market's willingness to fund growth (OSH burns cash), and takes secondary equity off the table for OSH for the near future. It should enable CANO to issue a similar security, should it need capital for growth or M&A in the future. The convertible bond's terms support the high revenue multiple valuations for the space.

Sell Side Coverage Expectations for CANO

> *Summary Thoughts: Some, or all, of the 12 analysts that cover OSH will cover CANO. The sell-side will need to either argue that (1) CANO and OSH are not comps, or (2) severally haircut CANO's numbers to not empirically conclude that CANO is worth less than mid $20s.*

It is never guaranteed that the sell side will cover a post SPAC company. In the case of CANO, I expect significant coverage with buy ratings in the $25 -$35 context: (1) JWS is one of the largest SPACs in the market, at $750 million, (2) the proforma float will be over $1.5 billion, (3) The SPAC sponsor is Barry Sternlicht, a very high profile executive, (4) all the analysts that cover OSH will have to respond to where CANO is trading, (5) initiating on CANO requires less than half the work of another company because all the "macro" is the same as OSH and (6) in terms of price target it will be mathematically difficult to justify a sub $20 price target given OSH's valuation.

Digging deeper into price targets, below is the comparable company analysis from the recent (3/15/21) Evercore ISI initiation of OSH (buy rated $75 target):

	Enterprise Value	Rev Growth '21	Rev Growth '22	Rev Growth '23	EV/'21 Revs	EV/'22 Revs	EV/'23 Revs
OSH	$11,688.4	**55.2%**	**51.2%**	**49.4%**	**8.5x**	**5.6x**	**3.8x**
OSH-PT	$16,008.3	**55.2%**	**51.2%**	**49.4%**	**11.7x**	**7.7x**	**5.2x**
ONEM	$4,565.1	27.0%	24.0%	24.3%	12.0x	9.5x	7.6x
TDOC	$17,384.6	32.5%	36.0%	29.1%	15.9x	8.6x	6.3x
AMWL	$4,388.7	13.0%	28.0%	33.7%	18.4x	16.3x	12.7x
HCAT	$1,844.5	11.5%	20.1%	19.0%	9.8x	8.0x	6.7x
PGNY	$4,458.5	55.2%	43.5%	39.4%	12.9x	8.3x	5.8x
GDRX	$15,468.0	35.3%	37.8%	37.6%	28.4x	21.0x	15.2x
HQY	$6,743.5	2.7%	7.1%	0.2%	9.2x	9.0x	8.4x
PHR	$2,007.1	23.2%	20.5%	18.0%	13.7x	11.1x	9.2x
Average		**28.4%**	**29.8%**	**27.8%**	**14.3x**	**10.8x**	**8.4x**

Using management estimates for CANO, we can compare the current CANO valuation to the peer group. Note that management projections assume: (1) zero benefit from Direct Contracting (expected to be a 7-8% tailwind in 2021 alone) and (2) no major acquisitions, despite over 100 active targets. The conservatism of CANO's projections (see section) are most manifested in the declining 2023 growth rate:

	Enterprise Value	Revenue Growth			EV / Revenue		
		2021	2022	2023	2021	2022	2023
CANO							
$12	5,670	74.4%	53.5%	38.1%	3.9x	2.5x	1.8x
$14	6,694				4.6x	3.0x	2.2x
$16	8,708				6.0x	3.9x	2.8x
$18	9,715				6.7x	4.4x	3.2x
$20	9,715				6.7x	4.4x	3.2x
$25	12,232				8.4x	5.5x	4.0x
$30	14,750				10.2x	6.6x	4.8x
$35	17,267				11.9x	7.7x	5.6x

In its January initiation of OSH, Wolfe put themselves in a relative box with regard to OSH vs. CANO. While the prices have moved slightly, the core picture is the same: CANO is trading at a ~50% discount

to OSH despite having comparable sales growth and positive EBITDA (CANO/JWS is third from the bottom and OSH is at the top).

	Ticker	Current Price ($)	Market Cap ($M)	EV ($M)	Sales ($M)		Sales Y/Y Growth (%)		EV/Sales	
					CY21	CY22	CY21	CY22	CY21	CY22
Oak Street Health	**OSH**	**$51.70**	**$12,451**	**$10,810**	**$1,256**	**$1,917**	**47%**	**53%**	**8.6x**	**5.6x**
High Growth HC Companies										
Health Catalyst	HCAT	$51.49	$2,188	$1,992	$226	$275	20%	22%	8.8x	7.2x
Teladoc	TDOC	$273.94	$39,711	$22,728	$1,972	$2,659	81%	35%	11.5x	8.5x
Progyny	PGNY	$44.30	$3,838	$4,279	$538	$758	57%	41%	8.0x	5.6x
One Medical	ONEM	$47.71	$6,346	$5,852	$474	$585	30%	24%	12.4x	10.0x
Healthequity	HQY	$90.23	$6,947	$7,816	$770	$813	6%	6%	10.2x	9.6x
Phreesia	PHR	$63.70	$2,737	$2,232	$180	$217	23%	20%	12.4x	10.3x
Amwell	AMWL	$42.80	$8,555	$8,970	$265	$336	11%	27%	33.9x	26.7x
Clover	CLOV	$14.25	$6,059	$1,471	$880	$1,219	31%	39%	1.7x	1.2x
Cano Health	JWS	$12.12	$836	$4,400	$1,453	$2,227	79%	53%	3.0x	2.0x
Caremax (Deerfield)	DFHT	$13.78	$198	$692	$94	$266	0%	185%	7.4x	2.6x
Average							**34%**	**45%**	**10.9x**	**8.4x**
Average ex AMWL							**36%**	**47%**	**8.4x**	**6.3x**
Median							**26%**	**31%**	**9.5x**	**7.9x**
Physician Providers Only										
One Medical	ONEM	$47.71	$6,346	$5,852	$474	$585	30%	24%	12.4x	10.0x
Clover	CLOV	$14.25	$6,059	$1,471	$880	$1,219	31%	39%	1.7x	1.2x
Cano Health	JWS	$12.12	$836	$4,400	$1,453	$2,227	79%	53%	3.0x	2.0x
Average							**47%**	**38%**	**5.7x**	**4.4x**
MCOs										
Humana	HUM	$377.93	$50,016	$50,137	$82,580	$90,558	9%	10%	0.6x	0.6x
UnitedHealth Group	UNH	$332.99	$315,948	$348,111	$278,806	$302,292	8%	8%	1.2x	1.2x
Average							**9%**	**9%**	**0.9x**	**0.9x**

Further supporting the valuation of OSH and JWS/CANO is the recent InnovAge Holding ("INNV") IPO. INNV focuses on the "PACE" program, which targets chronically ill seniors that need comprehensive in-home care. Like OSH/CANO, INNV receives a capitated payment from Medicare and assumes all risk of higher costs. INNV has grown revenue at a ~20% CAGR, substantially lower than OSH/CANO and has a far more difficult business to operate and scale. INNV recently went public and is trading at 5.4x EV/2021Revenue (~$16 per share for JWS/CANO).

	FY June 2016	FY June 2017	FY June 2018	FY June 2019	FY June 2020	FY June 2021
Revneue	234	273	319	466	567	625
		16.7%	16.8%	46.1%	21.7%	10.2%
Adj EBITDA				51	65	73
				10.9%	11.5%	11.8%
Centers	8	9	9	16	16	17
Members	3,100	3,700	4,100	5,900	6,400	6,600

		IPO		Current		
Price	19	21	23	25	27	29
Shares	138	138	138	138	138	138
	2,622	2,898	3,174	3,450	3,726	4,002
Net Debt	(75)	(75)	(75)	(75)	(75)	(75)
	2,547	2,823	3,099	3,375	3,651	3,927
2021E						
EV / Rev	4.1x	4.5x	5.0x	5.4x	5.8x	6.3x
EV / EBITDA	34.7x	38.4x	42.2x	46.0x	49.7x	53.5x

Addressing Churn

> *Summary Thoughts: Disclosures about churn rates have taken center stage since the analyst day. I do not believe this is an issue.*

At the recent investor day, CANO disclosed monthly patient churn of 2-2.5%. This number has lead to much angst among investors. After several calls with expert networks and CANO IR, I do not believe this is a major, or new issue. Churn rates, however defined, have not changed. CANO, and other companies in this industry, are consistently growing at substantial rates (CANO's organic growth rate is over 40%). The biggest negative of churn is that it has highlighted the risk of single payor dedicated facilities (a large portion of CANO's growth). The best defense to churn is to increase the number of relationships with insurance carriers; many patients will switch plans over price and not realize the new plan makes their existing PCP out of network. Wolfe published a note after a follow up call with the CEO:

> *While Cano's 30% annual churn rate is a surprisingly large number (OSH mgmt. indicated it "sounded high" but would not share their #), it is tough to know just how much weight to put on it when thinking about the value-based care model given continued strong growth and market opportunity here. At a minimum higher churn will increase Customer Acq. Cost (CAC), and it appears that companies with higher growth rates (especially new center openings) that focus on de novo centers with new docs vs. hiring docs w/loyal patient panels, older populations and higher Dual / Special Needs populations are likely to see higher churn rates vs. peers…*
>
> *… Cano noted that ~40% of churn is involuntary (the patient passes away, loses Medicare benefits or moves). Notably, Cano's average MA member is 74 years old (OSH avg. age is 69) with significant health needs, which likely contributes to higher churn. In addition, Duals typically churn more often (Cano est ~20% higher than typical Med Adv members as they can switch plans quarterly) and Cano has above average Dual penetration vs. Med Adv overall. Moreover, mgmt. added that higher churn will always be tied to the opening of new centers. Given patients new to a center have less loyalty to the primary care doc, Cano indicated that monthly churn at a new center starts at high-single digits for the first 90 days post opening, declining to mid-single digits by the end of year one and declining from there down toward 1% monthly or effectively the involuntary rate indicated above several years after center opening….*
>
> *… Finally, CEO Hernandez indicated that the co. has done 20+ acquisitions and it has not seen a center-based model with lower turnover than Cano's on a like for like basis.*

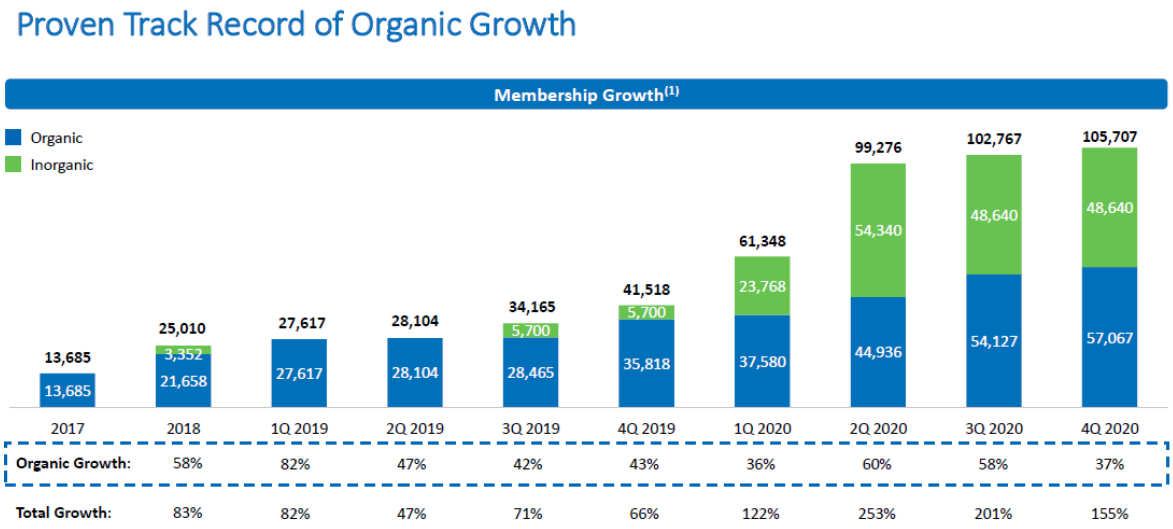
In communication with CANO's IR, I was told:

> *We think our churn rates are in line with those of similar provider-based organizations. It is important to note that Cano differs from MA plans (with lower historical churn) in a couple of important ways:*

(1) *First, MA plan membership changes tend to concentrate in the annual enrollment period, whereas Cano members are free to select or change their PCP at any time. In fact, that is a major selling point for seniors*
(2) *Second, Cano's membership base has a higher proportion of dual eligibles than the general MA market, about 50% of our members. Dual eligibles also often have less stable housing situations than other members, meaning switching rates in the dual eligible population may be higher than MA plans in general. Duals can also change plans throughout the year*

We have noticed that as our brand recognition, reputation and physical presence in an area grows, including multiple centers that members can choose from, our churn rates decline over time. With so much growth in recent periods, that is still a contributing factor. In addition, about 60% of our churn is members who have been with Cano a year or less. Overall, we believe that our churn rates are more comparable to other provider-based organizations, and MA churn rates are a less relevant comparator. <u>What is most important is the fact we continue to grow organically at a very strong and consistent rate.</u>

Historically organic growth by quarter for reference:



It has also come to light that OSH defines churn differently than CANO. OSH includes FFS members (which have a substantially lower churn than MA), and only considers them having left if they don't return for 18 months. The inclusion of FFS substantially alters OSH's churn numbers.

A senior executive at a national primary care company (competes with CANO) explained further:

Churn is much more favorable in MA…MA churn is 13%.....churn in MA isn't nearly as toxic as it once was…we are able to defend to against churn by contracting with multiple plans…so the patient switches plans and we still get them…the dual churn is definitely higher than the pure MA churn…however, the way that you guard against that is making sure that you have enough relationships with enough of the major plans in the region, you still have a relationship with that

individual… the duals are the difficult and challenging from a clinical and social risk perspective… People are churning because of plan economics or "life event" and not because of the PCP [Primary Care Physician] … churn matters only because the longer you have a patient, the more money you make…

Per the executive, the industry's approach to churn continues to evolve and has coalesced on improving insurance coordination services for the patient. If successful, this service will make the care provider (ie CANO and OSH) the point of contact for members as opposed to their insurance companies, a clear positive in reducing churn caused by change in coverage. This strategy will also increase the leverage of the providers over the payors.

Everyone is trying to build a mousetrap that is a navigation tool on the plan side…it is so critical to guide patients through that… Clinically, there is a certain portion of the population that benefits from FFS over MA….folks who have serious, complex illnesses, especially cancer. These folks want to be at centers of excellence like Mayo, who don't always take MA….FFS is almost always better than MA in terms of networks. That aside, it is almost always better to be in MA plan….this [dynamic] is why PCPs want to help members navigate the insurance side…there is an actual way to optimize everyone based on their clinical conditions on the insurance side, but so few folks are doing that….if we were optimizing everyone, it really only makes sense for 10-20% to be on FFS. Direct Contracting is a land grab [in terms of members]. Once people get really smart on the insurance side and optimizing, MA enrollment is going to accelerate even more than it has been…. As we push more people into MA, the number of insurance companies can increase. HUM just wants to worry about ALR as opposed to MLR…

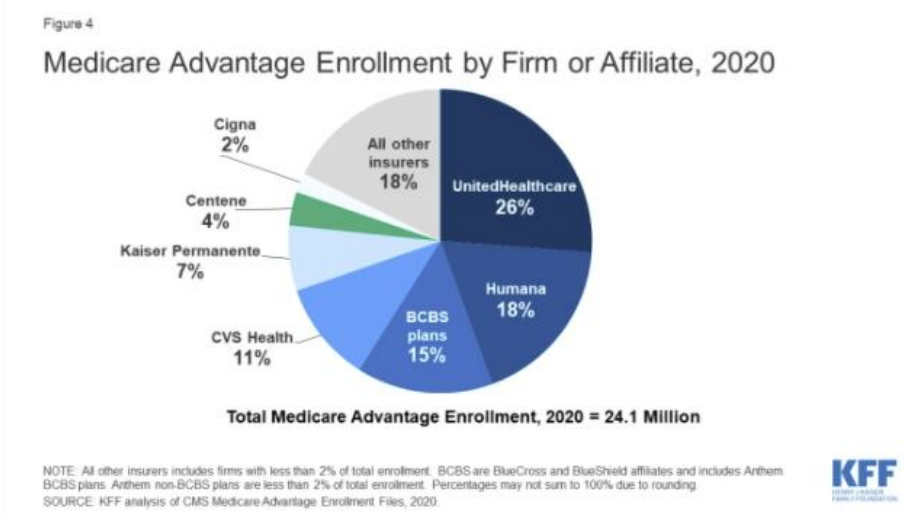
While unquantifiable, a meaningful portion of churn relates to the same patient merely switching plans, often from Medicaid Capitated to Medicare Advantage. CANO has ~50% dual eligible members as opposed to 45% for OSH. Yet, CANO gets about 20% of its revenue from Medicaid while OSH gets less than 3%; CANO's dual eligible used Medicare far more than OSH's do.

It does not seem apparent that CANO has higher churn than the industry, nor that it is experiencing something out of the norm. If anything, the "churn episode" has been a first "learning experience" for a CEO new to the public markets and communicating with investors.

Humana: The Biggest Counterparty

Summary Thoughts: Humana is the #2 player in Medicare Advantage and the largest partner for CANO (and OSH). Humana is committed to value-based care and will continue to help fuel the expansion of CANO (and its peers).

Humana ("HUM") is one of the big five insurance companies and a clear leader in Medicare Advantage with 18% market share (second only to UNH):

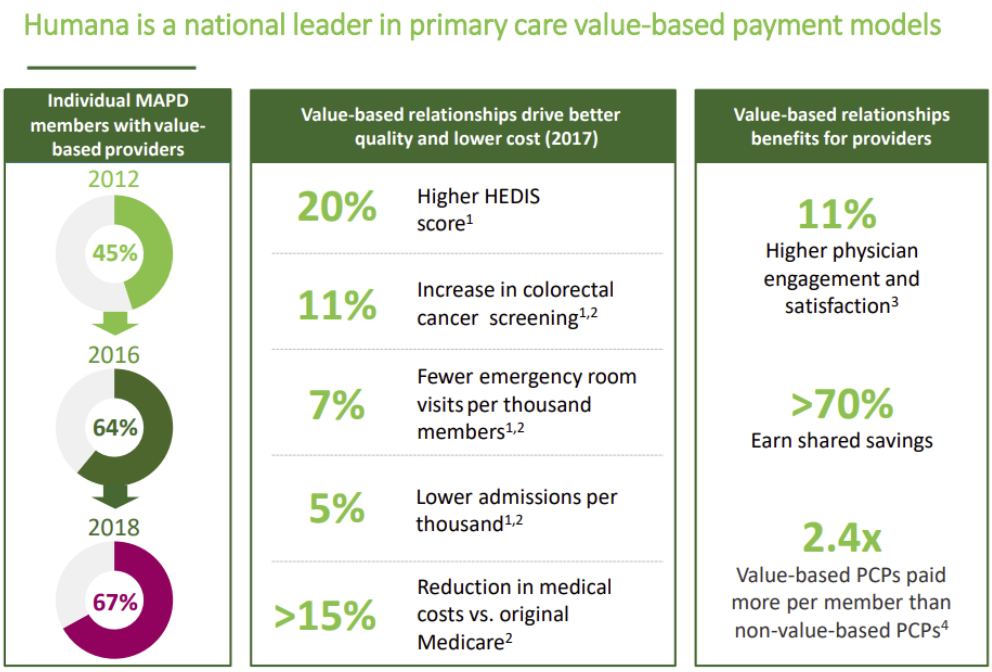


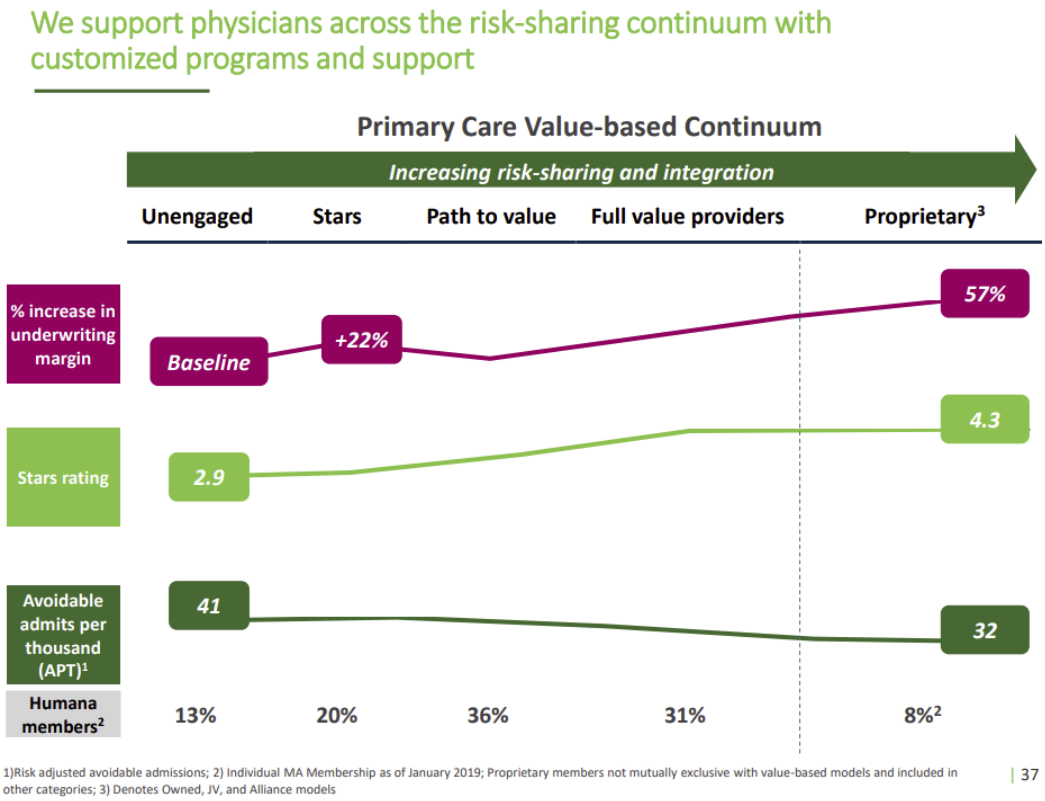
For both OSH and Cano, HUM is a key partner. HUM is an investor in both OSH and Cano. OSH derives 45% of its revenue from HUM, while Cano is HUM's largest provider partner in South Florida (HUM's largest market). HUM has made significant investments in primary care, both through owned clinics as well as partnerships (such as with OSH and Cano). From HUM's 2019 Investor Day (CANO is not mentioned as they did not become a partner with HUM until after the analyst day):

> *We've talked to you several times this morning about the importance of being local and we put this map up here to show you that we've built over a period of years a broad proprietary network of primary care models. Those models include not only our own brands of Partners in Primary Care, Family Physicians Group and Conviva care centers, but also our joint venture relationships and our unique contractual relationships…Collectively, we refer to these as our proprietary primary care models. Today, we operate those models in 30 markets across the country, and we're continuing our investment and expansion to bring primary care to local communities…These models are different from the traditional fee-for-service practices in that they focus on whole person care and they're expressly designed for the needs of seniors with chronic conditions. What makes these organizations different is that we tend to place these in communities that are medically underserved, in lower socioeconomic communities where the emergency room is typically utilized as the primary care office. We recognize that there is a shortage of primary care physicians and so we want to bring these services to communities that otherwise might not have them. What's also different about these is that they are built around*

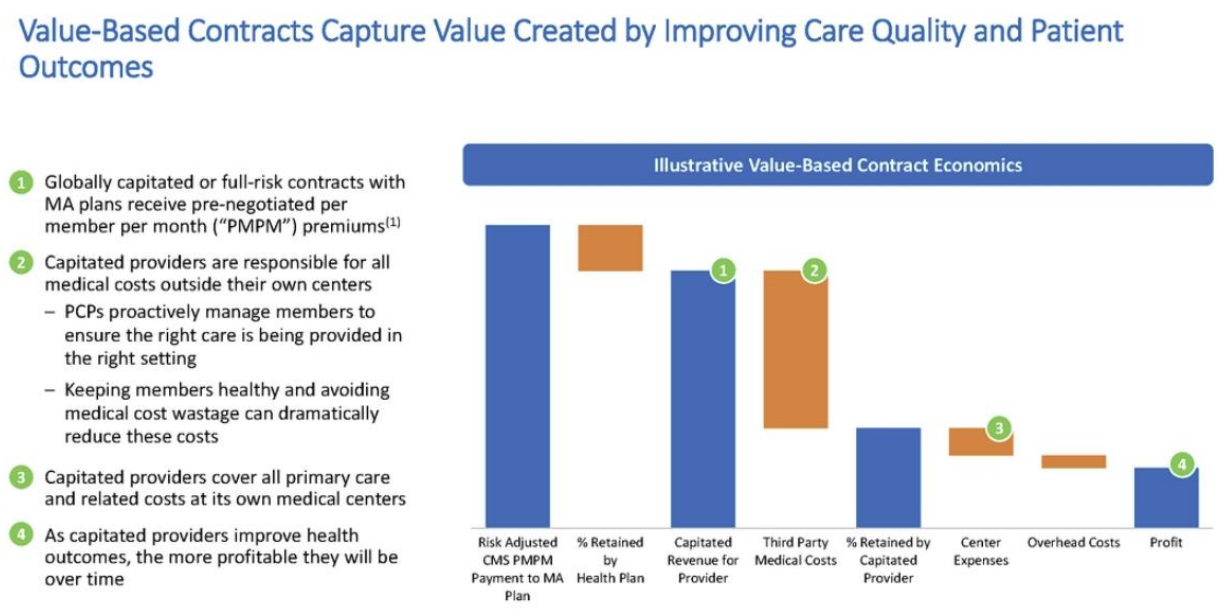
not only a primary care physician but a care team of clinicians. That includes a social worker, a behavioral health specialist and a care coach that all work collaboratively with the primary care physician to make sure that we are coordinating care and helping our patients navigate the entire health care ecosystem. Because this care model is built around this integrated care team, we limit the number of patients that the care team takes care of. So in our model, there are about 700 patients are managed by a care team. They see somewhere between 12 to 15 patients a day. Typically, our patients are highly complex, polychronic seniors, who require longer appointment times in order to ensure that we're addressing all of their needs, not only their clinical needs, but also many of their social determinants of health needs as well. The way in which we ensure that we can continue to make these kinds of investments is that we operate our centers within a value-based model. And so that means that we can make strategic investments in building out capabilities that we know deliver better outcomes for our patients, like providing social work inside a primary care practice, because we're not focused on the traditional fee-for-service transaction and billing of a specific service. We're accountable for the entire population and al the care that goes on relative to that population.

HUM has continued to innovate over time. Increasing investments in primary care (both owned and partnerships) is a core part of their strategy. From the 2019 Investor Day, they noted the large increase in members served by value-based providers (from 45% in 2012 to 67% in 2018), as well as improving patient outcomes. By shifting risk to providers, HUM is able to earn higher margins as well.



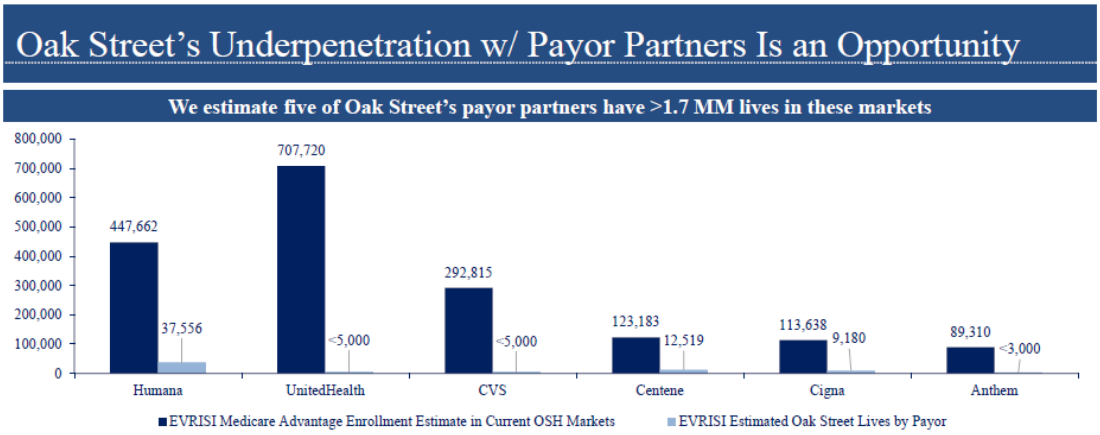


For HUM, and other insurance companies, part of the allure of partnering with primary care providers is to reduce earnings volatility- and likely lead to multiple expansion. As highlighted in the diagram below, from Cano's investor day, all of the risk is offloaded to the care provider, with the insurance company retaining a margin.



The contrast between HUM and UNH is the level of vertical integration. UNH is much more intent to vertically integrate and pave its own path. HUM is more mixed with its own primary care company (Partners in Primary Care), as well as investments in OSH, CANO and Iora Health. CANO's Hispanic focus is likely to increase the attractiveness of partnership for most payors as they have leadership in an important market niche.

The opportunity to scale with other payors is immense, even if UNH insources. For OSH, in their core markets, they are barely penetrated with any payor:



Will Humana Buy CANO?

In my diligence, there was a lot of open speculation in my diligence regarding HUM's interest in acquiring CANO. HUM has a ROFR, per the S-4:

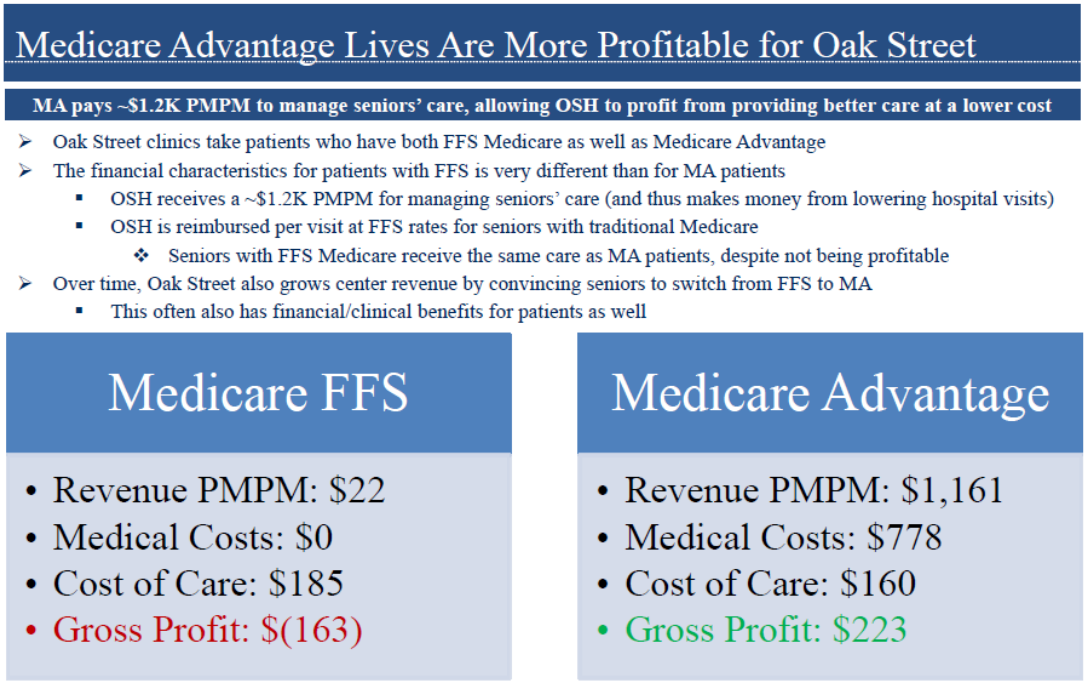
> *Humana has been granted a right of first refusal on any sale, lease, license or other disposition, in one transaction or a series of related transactions, of assets, businesses, divisions or subsidiaries that constitute 20% or more of the net revenues, net income or assets of, or any equity transaction (including by way of merger, consolidation, recapitalization, exchange offer, spin-off, split-off, reorganization or sale of securities) that results in a change of control of, PCIH, Seller, or the Company or its subsidiary, HP MSO, LLC.*

PCIH is the current parent entity of CANO. This ROFR was not exercised as part of the SPAC transaction or private equity auction (see section). I am skeptical that HUM pursues CANO. HUM has a ~$55 billion market cap and any transaction would be dilutive given the current earnings profile. At the current OSH implied value for CANO, the equity check would be over $5 billion (assuming 50% leverage).

Medicare Fee-For-Service Patients

> *Summary Thoughts: 1/3rd of OSH's members are in traditional Medicare Fee-For-Service. CANO does not serve these customers. OSH is betting that serving these patients, and accepting large near-term losses, will accelerate their growth. I believe CANO loses little by not covering these patients today.*

One of the largest differences between OSH and Cano relates to Medicare Fee-For-Service ("FFS") patients. About 1/3rd of OSH's patients are covered under FFS models as opposed to a negligible amount for Cano and several private players. OSH's strategy is to convert these FFS patients to MA over time. Yet, I have struggled to justify the large expense in serving these patients as the long-term benefits in higher organic growth have yet to show up. From the Evercore initiation on OSH (note much of the difference is the cost of care, which the primary care provider is responsible for under MA):



From the OSH S-1:

> *Traditional Medicare patients are those enrolled in traditional Medicare (i.e., are not enrolled in an MA plan). For these patients, we are reimbursed directly by CMS for the cost of our services based upon the Medicare fee schedule. Because we do not assume the risk of the total cost of medical care for these patients, the revenue we generate for our fee-for-service patients is significantly less than the revenue associated with our at-risk MA patients. We count fee-for-service patients as those that have completed a welcome visit at one of our centers and verbally communicated a desired interest in continuing to receive care at our centers. A fee-for-service patient remains active until one of the following occurs: (1) it has been 12 months since a*

patient's last visit; (2) a patient communicates a desire to stop receiving care at an Oak Street Health center; or (3) a patient passes away. Given the investment we make in care for our patients and the economics of fee-for-service Medicare, we generally experience a loss on Medicare fee-for-service patients, with a per-patient center-level contribution, after taking into account center costs, of approximately negative $184 per month. As centers mature, however, these losses decrease, as we are able to spread center costs over a larger patient base. However, we continue to experience a negative contribution in our tenured fee-for-service patients in earlier vintage centers, with a per-patient center-level contribution of approximately negative $164 per month for fee-for-service patients that have been with us for three or more years.

OSH loses on average $184 per month on FFS patients, with longer tenured patients costing $164 per month of negative margin. Over the life of OSH, they have lost well over $200 million serving FFS patients.

	2014	2015	2016	2017	2018	2019	2020
OSH FFS Patients	3,281	12,017	1,270	16,735	20,067	30,621	32,500
Average FFS Patients	1,777	7,649	6,644	9,003	18,401	25,344	31,561
Loss PMPM	($184)	($184)	($184)	($184)	($184)	($184)	($184)
Loss PMPY	($2,208)	($2,208)	($2,208)	($2,208)	($2,208)	($2,208)	($2,208)
Estimated FFS Losses ($ MM)	(3.9)	(16.9)	(14.7)	(19.9)	(40.6)	(56.0)	(69.7)
Cumulative FFS Losses ($MM)	(3.9)	(20.8)	(35.5)	(55.4)	(96.0)	(151.9)	(221.6)

The "bet" that OSH is making is that they will be able to convert these FFS patients to MA over time. Direct Contracting is an accelerant for the conversion as it allows the immediate uplift of many patients. That said, it is unclear whether OSH's approach is optimal. Cano serves a minimal amount of FFS patients and has positive EBITDA. OSH has negative EBITDA.

Perhaps the original impetus for OSH serving FFS clients at a loss relates to it geographic exposure. OSH was founded in the Chicago area. Cook County (Chicago) has below average MA penetration. As of 2016 it was just 22.8% vs. 32.8% nationally. OSH had the issue of both (1) recruiting patients (2) getting patients to switch to MA. Cano's original market was South Florida; the three counties that comprise this area are combined below (Miami-Dade, Broward and Palm Beach).

	2016	2017	2018	2019	2020
Cook IL					
Medicare	607,364	590,171	588,023	581,071	560,012
Medicare Advantage	179,457	207,467	221,955	242,009	269,570
Total	786,821	797,637	809,978	823,080	829,582
MA Penetration	22.8%	26.0%	27.4%	29.4%	32.5%
Medicare YoY		-2.8%	-0.4%	-1.2%	-3.6%
Medicare Advantage YoY		15.6%	7.0%	9.0%	11.4%
Total YoY		1.4%	1.5%	1.6%	0.8%
IL Total					
Medicare	1,645,577	1,632,353	1,635,322	1,623,815	1,580,651
Medicare Advantage	463,068	517,267	558,302	609,427	683,311
Total	2,108,645	2,149,620	2,193,624	2,233,242	2,263,962
MA Penetration	22.0%	24.1%	25.5%	27.3%	30.2%
Medicare YoY		-0.8%	0.2%	-0.7%	-2.7%
Medicare Advantage YoY		11.7%	7.9%	9.2%	12.1%
Total YoY		1.9%	2.0%	1.8%	1.4%

	2016	2017	2018	2019	2020
South Florida Three					
Medicare	491,356	488,382	484,039	480,575	469,381
Medicare Advantage	549,334	577,705	604,984	637,372	669,488
Total	1,040,691	1,066,087	1,089,022	1,117,947	1,138,871
MA Penetration	52.8%	54.2%	55.6%	57.0%	58.8%
Medicare YoY		-0.6%	-0.9%	-0.7%	-2.3%
Medicare Advantage YoY		5.2%	4.7%	5.4%	5.0%
Total YoY		2.4%	2.2%	2.7%	1.9%
Florida Total					
Medicare	2,466,777	2,468,028	2,459,571	2,455,795	2,407,255
Medicare Advantage	1,696,922	1,827,188	1,953,129	2,100,816	2,268,094
Total	4,163,699	4,295,216	4,412,700	4,556,611	4,675,349
MA Penetration	40.8%	42.5%	44.3%	46.1%	48.5%
Medicare YoY		0.1%	-0.3%	-0.2%	-2.0%
Medicare Advantage YoY		7.7%	6.9%	7.6%	8.0%
Total YoY		3.2%	2.7%	3.3%	2.6%

The other negative in serving FFS patients is that it perversely reduces the potential economics that you can earn once you transition a patient to a capitated model (either MA or DC). Per a senior executive in the primary care industry (whose company does not cover FFS patients):

> *Yes, it kind of turns back to OSH. With their FFS patients, if they are managing them well, they are kind of shooting themselves in the foot right now. It's a weird…I don't know how to make sense of that. A great example is when we were building these models out….its just not sustainable as things are now; you do a good job [with a patient] and you end up shooting yourself in the foot [risk score goes down and revenue decreases].*

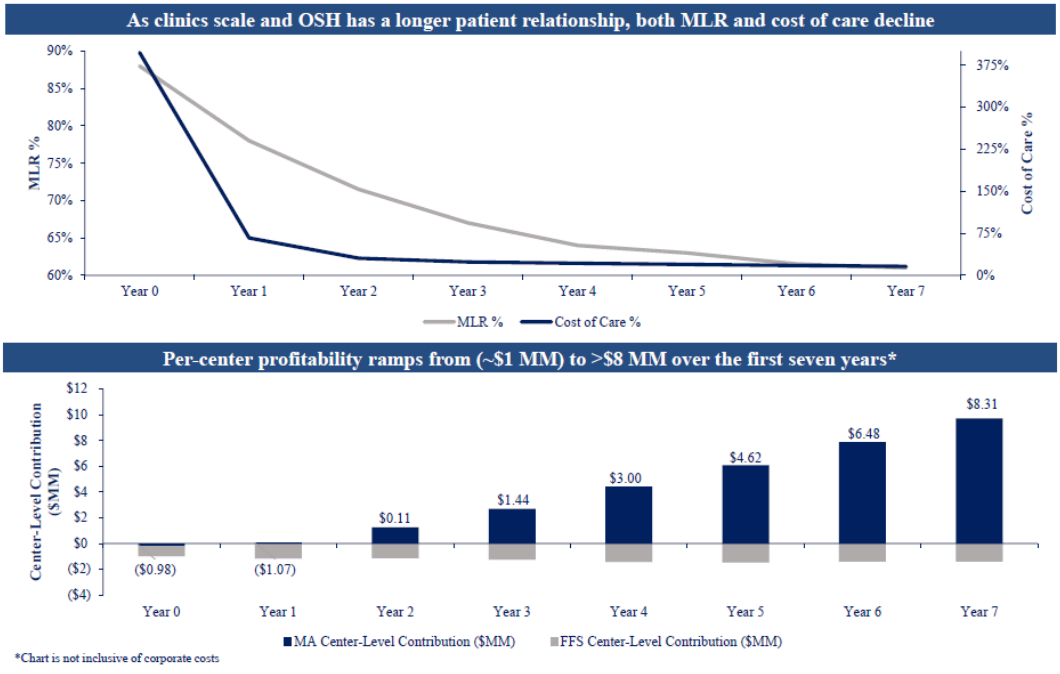
De Novo Economics

> *Summary Thoughts: CANO has superior De Novo economics as compared to OSH. OSH has opened far more De Novo facilities, and its planning to open more than CANO in the near term.*

In addition to funding losses on FFS patients, OSH spends considerably more than Cano on sales and marketing. OSH spent $64 million in 2020 marketing to new patients vs. less than $5 million for Cano. Indeed, OSH estimates that it costs ~$5 million in total to bring a de novo facility up to capacity (from the Q4 2020 earnings call):

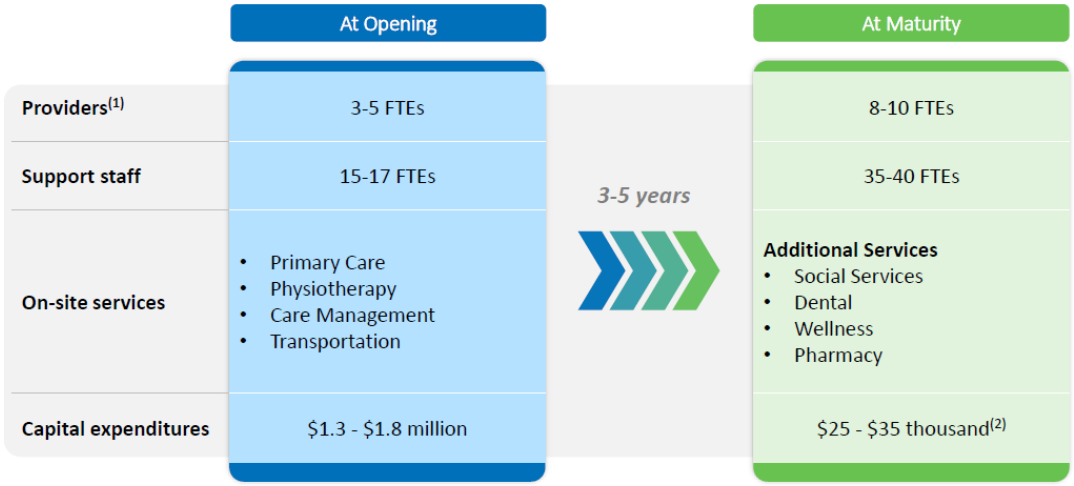
> *With less than $5 million total capital invested, including CapEx, operating losses, sales and marketing and overhead, our centers nearest capacity now have a contribution of $9 million annually and growing.*

The $9 million per center referenced relates to just 4 centers out of a total of over 80 that OSH has built. Their most recent "cohort" disclosures show current revenue per center of $2.2 million / $1.45 million / $1.13 mm / $0.624 million of the last vintages. Evercore projected OSH's De Novo economics in their initiation:



Cano, owing to its better geographic exposures, has significantly better De Novo economics. Year 3 EBITDA is ~$1.8 vs. $1.44 for OSH. From CANO's analyst day presentation:

De Novo Maturation



Illustrative Cano Medicare De Novo Center Ramp

(PMPM in $, revenue and EBITDA in $ millions)

Medicare At-Risk	Year 0(1)	Year 1	Year 2	Year 3
% of Capacity(2)	8%	24%	44%	56%
Member Months	500	5,000	10,000	15,000
Members at Year End	200	600	1,100	1,400
Premium PMPM	$981	$1,037	$1,113	$1,145
Total Revenue(3)	$0.5	$5.2	$11.1	$17.2
Total EBITDA(4)	($0.3)	($0.9)	$0.1	$1.8

Consistent and successful track record of growing de novos

A further analysis of historical Cano De Novo's supports the illustrative economics. The question for Cano is whether these economics can be scaled further.

Facility	Region	Year	Capital Cost	Time to Break-even	Annualized EBITDA	EBITDA / Cost	Capacity Utilized
De Novo 1	So FL	2017	977	3 Months	3,840	3.93x	65%
De Novo 2	So FL	2017	172	1 Months	1,332	7.74x	59%
De Novo 3	So FL	2019	1,439	5 Months	760	0.53x	36%
De Novo 4	So FL	2019	2,649	7 Months	528	0.20x	33%
De Novo 5	Cen FL	2019	2,091	5 Months	1,744	0.83x	56%
De Novo 6	West FL	2019	727	5 Months	808	1.11x	70%
De Novo 7	So FL	2020	2,103	5 Months	19	0.01x	19%

OSH is planning on ~40 De Novos in 2021. Cano has plans for 29 new centers in 2021, with most of the growth as a result of the HUM relationship in Nevada and Texas. These facilities are not true De Novos in the sense that HUM is putting up the capital and the facilities are only serving patients with Humana insurance.

De Novo vs. Acquisition vs. MSO and the Question of Execution

> *Summary Thoughts: OSH's "De Novo only" strategy is unique in the industry and will lead to slower growth. CANO's three-pronged growth strategy leads to faster growth and more cash flow. If CANO can replicate its success in the Tampa market, it is likely that OSH will either have to shift strategy or its stock will trade at a discount to CANO.*

The market opportunity for value-based primary care providers is incredibly large. There are divergent views on how best to scale and capture new members. OSH is unique in its "De Novo Only" approach to growth. This is partially borne out of conservatism. From the January JPM Healthcare Conference:

> JPM Analyst: I want to ask about competition a little bit, but maybe not in the traditional sense. If we say that imitation is the best form of flattery, I've never seen so many investor decks from a SPAC or private companies, et cetera. Everybody is comparing themselves to Oak Street. So you haven't just captivated the investor market. You've kind of -- you've captivated the industry as well. But Mike, when you walk through how you flow up through creating Oak Street and what was going to be important to change how medicine is practiced, you hit on a few things. A business that's primarily built through de novo versus acquisition, a business that so far has been exclusively focused on Medicare versus the commercial market, a model that's exclusively focused so far on employed physicians versus an MSO IPA model, a business, whether coincidentally or intentionally Midwest origins versus South Florida, for example. Which of those characteristics do you really think are most important? And can you just sort of touch on why you made some of those decisions that you did because investors over the next couple of years are going to be looking at all sorts of competing models that have reached different decision points on some of those characteristics.
>
> *CEO Mike Pykosz: Yes. Look, first off, I hope there's multiple models that are able to achieve the success of Oak Street and what we needed in society, and it's such a massive market that when we think about what is going to be inhibitor to our growth, it's certainly not competitors, isn't on the list. It's our ability to execute, it's our ability to continue to articulate our value proposition to older adults, et cetera, because it's just such a huge, huge market size. I do feel like to -- the challenge with our model, right is, it's a little slower, right? We've got to open up centers, we've got to hire teams, we've got to train them up. We've got to onboard new patients one by one. I showed you earlier, it's not like our growth rate is slow, right? We have a 67% revenue CAGR, but it is much more methodical, right, and it's more capital intensive. So some of these other models can go out and buy groups faster and kind of ramp faster. But I think the challenge that they're going to face and why I think we're really excited about our model is, how are you really changing the way care is delivered? Because at the end of the day, that's what's really going to drive better outcomes through patients. That's going to drive sustainable economics in the model. It's really changing the underlying care that is delivered, both from an experience perspective and a care model perspective. And so that's why focusing on one population, so you can optimize the model for that population is critical. It's hard enough to do what we do just for our population, let alone having multiple populations. That's why tested de novos are so important. The "health care is local kind" of phrase, I think, stems from the fact that most*

regions are very different from how providers are organized. Even within a region, a lot of provider groups have very different kind of characteristics and politics and focuses, and so by using our de novo approach and controlling all of that, we don't [want] to kind of have a bespoke approach to every group, but we can do the same thing very consistently everywhere. And so I think that focus and that consistency of how we apply our models, what drives consistency of experience, drives consistency outcomes, allows us to create more of a brand over time, and I think really drives that consistent scalability.

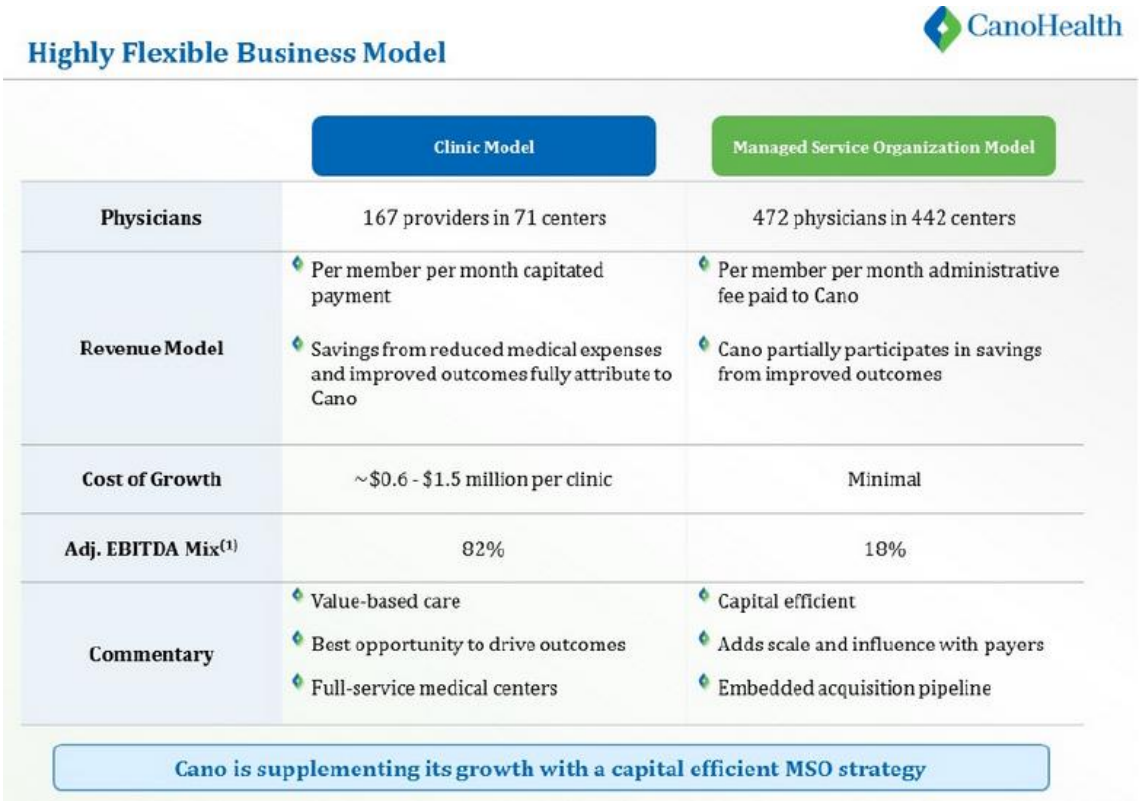
CANO has pursued a three-pronged growth strategy of De Novo, MSO and M&A. This approach has made CANO's growth lumpier and batch.

De Novo: CANO intends to open 15-20 De Novo facilities annually vs. OSH's 40 per year target. Over the last two years, they have opened ~8 per year. Much of the De Novo growth is tied to the HUM partnership in Nevada, Texas and California.

MSO: CANO has a large MSO footprint. Puerto Rico is 100% MSO and accounts for 40-50% of all affiliated physicians. Florida is a mix. The MSO model allows CANO to expand its network more rapidly by providing technology, back-end support, and care management to smaller physician practices. It also acts as a funnel for future acquisitions. Most MSO affiliates are single clinic PCPs with 1-2 doctors. These PCPs benefit from CANO's scale, tech solution and operating expertise.

M&A: CANO has a history of successful acquisitions. Its two most recent large acquisitions, Belen (2019) and Health Partners (2020) appear to be successful. CANO has identified a backlog of over 100 potential acquisition targets. *M&A is extremely common in this industry*. The private primary care companies (Iora, Partners in Primary Care, United Health, etc) are all extremely acquisitive. A much smaller primary care company going public via SPAC (DFHT / Caremax) has a business plan almost entirely based on M&A. OSH stands out for its lack of desire to do M&A.

From the November deal slides, a comparison of relative economics between Owned vs. MSO is below. Yet, it shouldn't be thought of as an either or as many MSO affiliates will transitioned to being owned over time. Based on my diligence, the average MSO member is ~70-80% as valuable as fully owned members on an EBITDA basis (a portion of the economics go to the PCP). However, as shown in the slides, there is no capital cost:



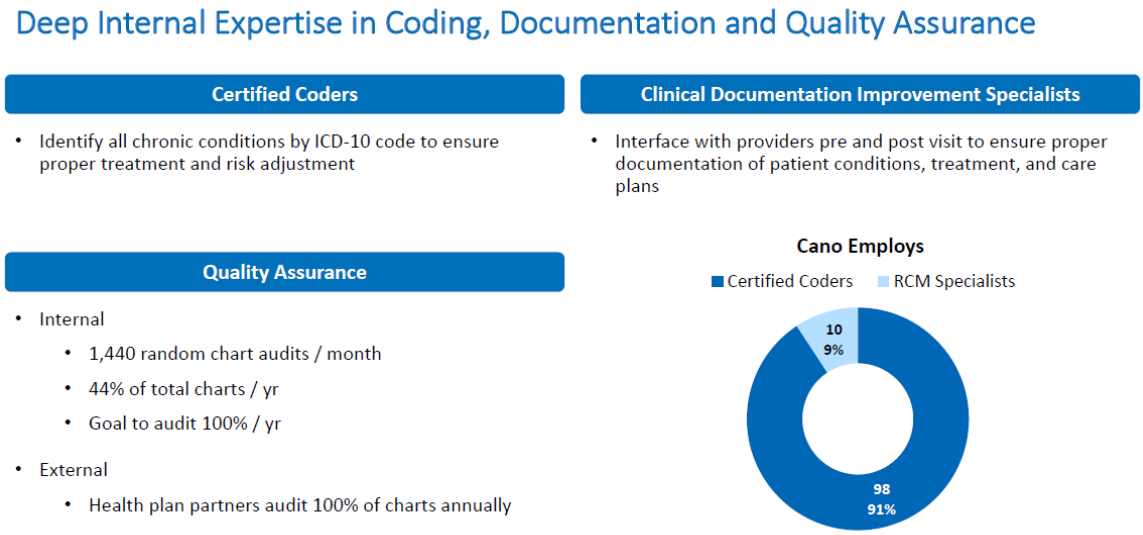
As compared to OSH, CANO, through its multi-pronged approach, can achieve scale in market faster. Scale in market is critical as it means better doctors, greater ability to reduce 3rd party medical costs (monopsonist), and ultimately better profitability (reduces cash flow burn). Per a senior primary care executive:

> *Get a certain base, and then expand. You are buying patients… De Novo is really tough…the MSOs are not thinking in this way…so just go out there and buy patients… There is a large value proposition in this space just by doing coding adjustments… nothing illegal is going on. We are coding them correctly…no one cared about these patients under Fee for Service…if you look at patient outcomes, the patients are doing better…has better outcomes just on the numbers than a typical Fee for Service patient…*

Multiple industry executives mentioned the term "land grab" in my diligence. They argue that the upside from coding adjustments is so large, that it will excuse a lot of mistakes. The skeptics on CANO, and there are many, when pressed further usually relented and conceded that even if the deals are "bad," the upside from coding adjustments on new patients is so large that it would be 3-5 years for any problems to matter financially:

> *…yes there is this relatively easy lift [on rates / revenue] from proper documentation and the disease burden [of new patients], you have to remember that you are taking risk on these medical costs…unless your clinical model is robust you can get into trouble too…that said, the "blow up risk" is 3-5 years away [as opposed to 0-2 years], you can look really good for two years [because of the coding upside] and then it's going to catch up with you..*

The "easy lift" is relevant for MSO affiliates as well as acquisition candidates. The complexing of coding alone, coupled with the upside that comes from it, is substantial. At the Investor Day, CANO added this slide into the appendix, highlighting 98 internal coders and 10 RCM (revenue cycle management) specialists:



In explaining the desire for doctors to either sell their practice outright, or join as an MSO affiliate, one expert I spoke to noted:

> *They [the selling doctors] do not know what they are able to do. No one has ever scaled it. They didn't get in the business to maximize value, they are just trying to run a clinic. They have no idea how scalable their businesses are. They sell, and it looks attractive to them, that is just the way it is…these selling doctors also want to retire…they don't know how to even use EMRs [electronic medical records]…if they can leave with a little bit of cushion all the better…some become MSO affiliates as a first step and end up selling shortly thereafter….*

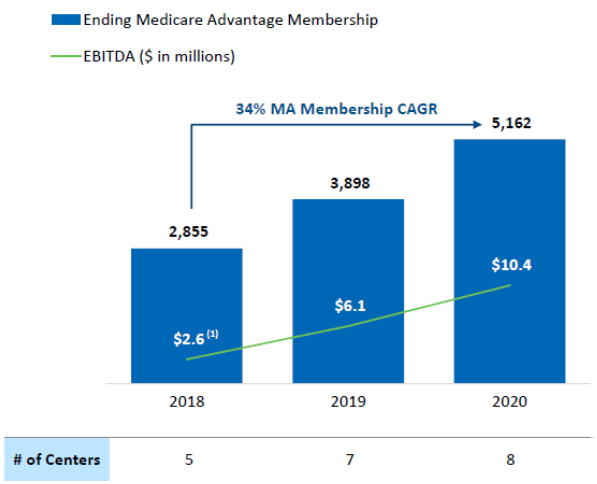
Digging deeper, it became clear that much of the industry skepticism on CANO was not based in empirical evidence; contrary to market chatter, CANO has been buying high quality assets at attractive prices:

> Belen: Paid $110 million / 1.3x Revenue. 2018 / 2019 / 2020 revenue and net income were $51.5 / $72 / $80.5 million (revenue) and $10.8 / $18 / $21 million (net income). Post acquisition, Belen continued to grow, and the margins are improving. ~5.0x pre-tax cashflow seems reasonable.
>
> Health Partners: $195 million deal in 2020. Historical MLR is 69% (inline with CANO). ~9% EBITDA margins (better than CANO) and $29 million of LTM net income.

Historically, CANO has paid ~7.5x EBITDA for acquisitions and has been able to further grow the assets post deal. Over the last several years, CANO has completed over 20 deals with a total value of over $500

million. Tampa is a highlighted case study. CANO entered the market in 2018 through acquisition; they paid $20 million for $70 million of revenue (0.3x). The seller, Dr. Orlando Rangel, is now a regional president for CANO. From this footprint, CANO has since expanded to 8 medical centers, over 5k members and $10.4 million of EBITDA. Note from the slide that several MSO affiliates were later tucked in, and are now owned facilities.

Multi-Pronged Growth Strategy: Tampa Case Study



Commentary

- In Tampa, Cano Health has used its multi-pronged strategy to drive robust growth with multiple payers
  - 1Q18: Entered market with acquisition of two medical centers and affiliate network
  - 3Q18: Opened first de novo medical center
  - 4Q18: Converted two affiliates to owned centers
  - 2019: Opened one de novo and converted one affiliate to owned center
  - 2020: Opened one de novo

Results like Tampa are not possible, in this time frame, under a "De Novo only" strategy. The combination of M&A, MSO and De Novo only in Tampa also appears to have lower execution risk than had CANO attempted to enter the market in the "OSH way." Note that economically, OSH believes its De Novo facilities cost ~$5 million each, the same price CANO paid for its market entry with two cash generating clinics.

Actual and Projected Financial Performance

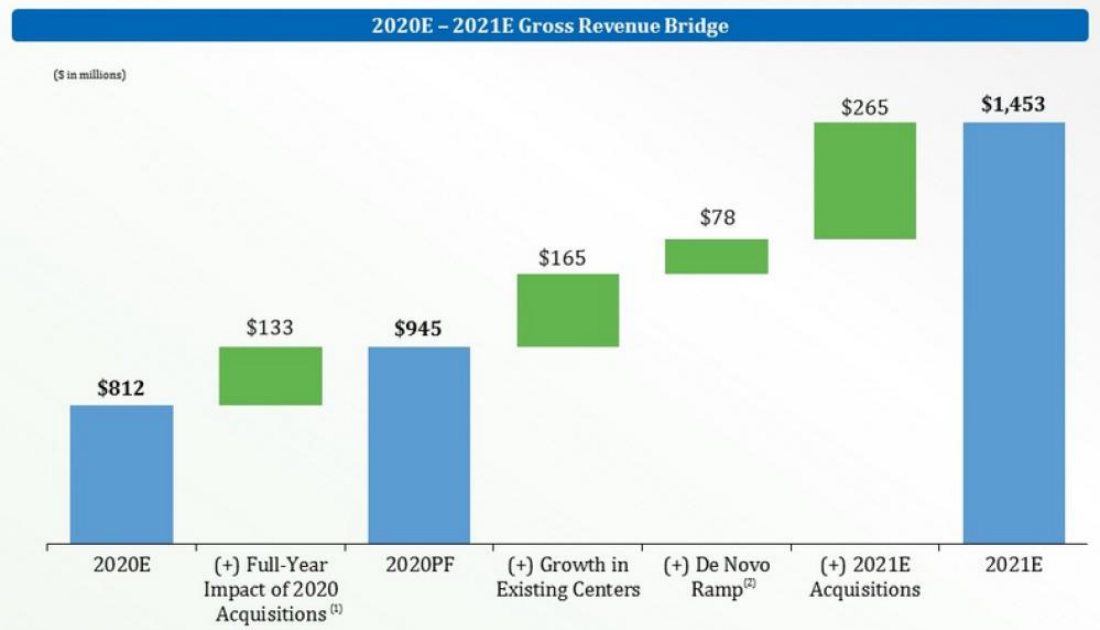
CANO first gave financial details and projections at the time of the deal announcement in November. At the March Investor Day, CANO reported Q4 numbers above projections, with full year 2020 Revenue / EBITDA coming in at $833 / $70 vs. estimates in November of $812 / $64 million. While early in the public company journey, starting off with a Q4 beat is helpful for credibility.

				At SPAC Merger (Nov 2020)				March 2021 Investor Day			
	2017	2018	2019	2020	2021	2022	2023	2020	2021	2022	2023
Members	14	25	42	109	160	233	299	106	158	230	300
Revenue	130	235	365	812	1,453	2,227	3,079	833	1,453	2,230	3,100
3rd Party	79	158	241	550	1,028	1,617	2,250	570	1,028	1,619	2,265
Medical Expenses	*60.8%*	*67.2%*	*66.0%*	*67.7%*	*70.8%*	*72.6%*	*73.1%*	*68.4%*	*70.8%*	*72.6%*	*73.1%*
Opex	39	62	100	198	342	491	657	194	330	476	640
	30.0%	*26.4%*	*27.4%*	*24.4%*	*23.5%*	*22.0%*	*21.3%*	*23.3%*	*22.7%*	*21.3%*	*20.6%*
Adj EBITDA	12	15	25	64	83	119	172	70	95	135	195
Margin	*9.2%*	*6.4%*	*6.8%*	*7.9%*	*5.7%*	*5.3%*	*5.6%*	*8.4%*	*6.5%*	*6.1%*	*6.3%*

At the March Investor Day, they also gave initial 2021 guidance:

($ in millions)	2021E Guidance
Total Owned Medical Centers	95-105
Total Members[(1)]	154,000 – 162,000
Total Revenue	$1,400mm – $1,500mm
Total Adjusted EBITDA	$90mm – $100mm

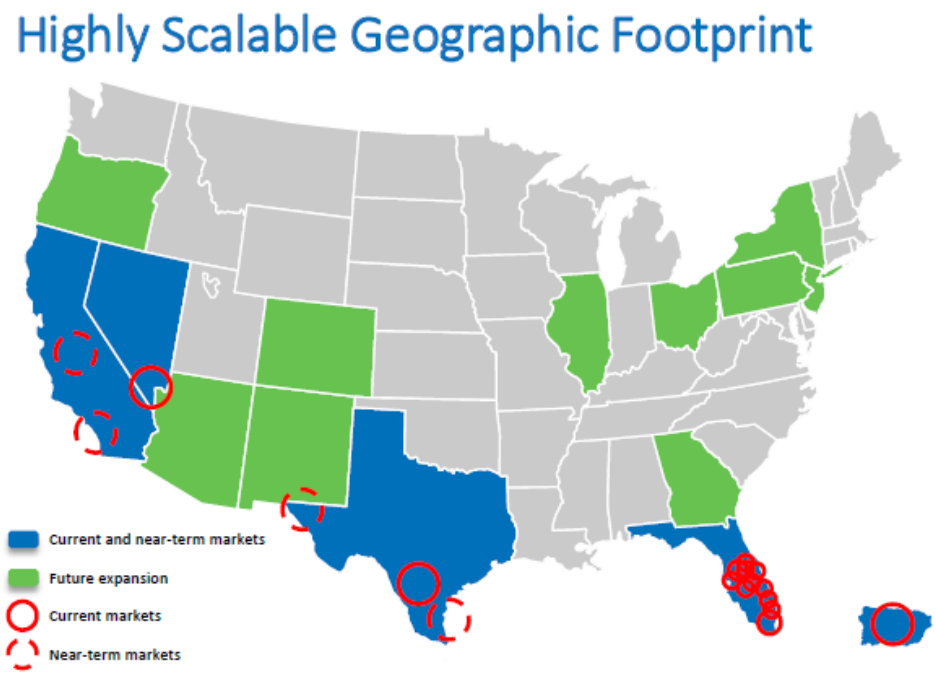
The formal guidance expands upon the detail given in the November deal announcement. While the $265 million of revenue from acquisitions is a big portion of growth, it is well within historical experience. As a public company, CANO should find acquisitions easier than when it was private.



For context, much smaller rival CarMax ("DFHT"), which is a small SPAC transaction, is assuming similar revenue growth. Its projections from the December deal deck have ~$200 million per year of acquired revenue vs. a current revenue base of ~$360 million.

CANO's growth strategy is likely understated by the projections. Especially in 2023. The core of the strategy:

> *Drive Organic Growth: CANO's South Florida footprint operates at only 50% capacity. Puerto Rico is still nascent and a large opportunity with the potential to grow from ~10k members to 30-40k over the next few years (market is ~670k). Other new markets (Tampa, Texas, Nevada), driven by Humana partnership, continue to ramp. CANO intends to build 15-20 de novos annually. The company plans on entering multiple new markets and is less geographically diverse compared to other players:*



Continue to Execute M&A and MSO Expansion Strategy: Over $500 million of deals in the last few years with a current pipeline of more than 100 deals. MSO model allows for multi-step transition for selling PCPs and increases the acquisition funnel.

Direct Contracting: Not in numbers. Triples the TAM and accelerates penetration of Medicare Advantage and Value-Based Care Models. One of 41 providers selected in a pilot and dominant player in South Florida. CANO estimates over $130 million of additional revenue from DC in 2021 that is not in projections.

The open question for the sell-side, and the stock, is how soon the market can get comfortable with the sustainability of the growth.

How We Got to SPAC

CANO has a unique history. The company was founded in 2009. In 2017, InTandem Capital merged CANO with Comfort Health, another primary care provider. In February 2020, CANO / InTandem launched a private equity sales process to monetize the company. Per sources, the process yielded 2-3 formal bids for the company by October in the ~$2 billion context. Towards the end of the auction in September, and subsequent to OSH's IPO in August, JWS entered the fray and by October had made a bid of ~$5 billion for CANO. However, the PIPE process was not immediately successful (SPAC market had temporarily frozen at that point) and the parties agreed to reduction in price to $4 billion. Per sources, CANO did not consider an IPO as they wanted more transaction certainty.

The muted deal reaction to the JWS/CANO deal announcement (the price of JWS faded post announcement to $11 per share) was partially driven by the market discovering the large gap between the private equity bids and the SPAC deal price. Sources close to the private equity bidders were near universally positive on CANO and its prospects but noted they are hamstrung by being "somewhat anchored to not paying more than 20.0x EBITDA."

SPAC Considerations

The SPAC transaction is currently expected to close in late April or May. The vote has yet to be scheduled. Key issues related to process:

Deal Certainty: The deal is almost certain to close. 2/3rd of holders can redeem and the "minimum proceeds condition" will be met

PIPE: Listed names in the PIPE are Barry Sternlicht (SPAC sponsor), Fidelity, Blackrock, Third Point and Maverick. Fidelity and Third Point have bought more JWS prior to close.

PIPE Unlock Technical: The $800 million PIPE will unlock with the merger. The $750 million not owned by the SPAC sponsor may partially release into the market. It is notable that Fidelity and Third Point have been adding. There may be a technical headwind for some time as the PIPE shares hit the market. The existing OSH shareholder base has already started to buy JWS and is a natural place for new buyers.

Thoughts on Terminal Value

While it is easy to look at OSH's valuation, CANO's projections, the trends in Medicare Advantage, the promise in Direct Contracting and lay out a nice spreadsheet and "plug and chug…" it is fair to consider what can go wrong. This is not an infinitely scalable tech business. Just to reach 300,000 patients (CANO's 2023 projections) will require CANO to open over 100 new clinics, hire over 1,000 doctors and establish a foothold in multiple new states. History is littered with the carcasses of many capable people who have tried to roll-up physician practices and expand nationwide. To be successful, these businesses will need to both improve care and be profitable. CANO project its long-term EBITDA margin range of 15-20%. Both CANO and OSH believe individual medical centers can have 25% margins. At some point there will be a need to demonstrate some level of profitability; OSH is currently worth ~$14 billion and has $1.3 billion of 2021E revenue and negative EBITDA. Assuming they hit their terminal margin target, and trade at 20.0x EBITDA in the end (no slam dunk), you have to believe revenue becomes $3.5 billion and EBITDA is $700 million at some point ($700 x 20 = $14 billion).

One of the industry executives I spoke with compared this space to mental health (which printed money for years):

> *If you take the bear case on this entire space, it is sort of like mental health….at the end of the day the limiting factor is whether there are enough mental health providers…for this industry it is a question of whether there are enough providers and I don't think enough is addressing that in a sober way…*

In the near term, I think the certainty and pace of growth will win the day. I do believe we are still in very early innings of a multi-year period of an immensely favorable backdrop for these assets. Money is flowing into this space a lot faster than it is flowing out. Yet as time goes on, there will be winners and losers in this space- as there always are.

Appendix 1: Other Players in the Industry

There are several other players in the industry in addition to CANO and OSH:

ChenMed: Multi-state player. Family owned and widely presumed to always remaining a private company. Reportedly, they have the lowest MLR of scaled players. They have ~80 clinics (roughly the same size as OSH and CANO). ChenMed has a Christian / Faith-based niche.

Partners in Primary Care: Humana owned. They are not exclusive to serving HUM members. 57k members across 60-65 centers. They are aiming for 100 centers by 2023 (CANO and OSH are targeting 300 by that time)

WellMed: UNH's MA focused primary care provider

Iora Health: Similar to OSH and CANO. HUM is their biggest customer. They had 48 clinics at the start of 2020.

DFHT / CareMax: Smaller SPAC merger announced after JWS deal. It is a merger of two clinic chains. The Chairman has a great pedigree (same guy as AHCO) and they plan to grow through M&A. It is Florida focused. Eminence, Maverick, Fidelity and Blackrock are in the PIPE. The deal valuation is 1.3x revenue. I have an investment in DFHT.

	State % of MA	State % of D-SNP	MA Ptration	HUM Share	CANO	OSH	PIPC (HUM)	WellMed (UNH)	Village MD	Iora Health	ChenMed
1 CA	11.9%	13.3%	45%	3%	X						
2 NY	6.6%	8.4%	44%	5%		X					
3 FL	9.3%	7.8%	49%	32%	X			X	X		X
4 TX	7.5%	6.5%	43%	30%	X	X	X	X	X	X	
5 PA	5.1%	4.2%	45%	6%		X					X
6 OH	4.5%	3.4%	46%	15%		X					X
7 IL	2.8%	3.4%	30%	25%		X			X		X
8 GA	3.1%	3.1%	43%	25%		X			X	X	X
9 NC	3.4%	3.0%	41%	23%		X	X			X	
10 MI	4.1%	2.9%	48%	10%		X			X		
11 MA	1.5%	2.9%	27%	0%						X	
12 TN	2.4%	2.4%	43%	24%		X					X
13 AZ	2.4%	2.1%	43%	17%					X	X	
14 NJ	2.2%	2.0%	32%	1%							
15 LA	1.5%	2.0%	42%	52%		X	X				X
16 IN	1.9%	2.0%	36%	29%		X			X		
17 AL	2.0%	2.0%	46%	31%							
18 VA	1.6%	1.8%	25%	40%							X
19 WA	2.1%	1.8%	37%	12%						X	
20 CT	1.3%	1.7%	45%	0%						X	
21 MO	2.0%	1.7%	40%	15%			X				X
22 KY	1.5%	1.6%	39%	51%					X		X
23 WI	2.3%	1.6%	46%	12%							
24 SC	1.5%	1.5%	33%	33%		X	X				
25 MS	0.6%	1.5%	24%	57%		X					
36 NV	0.9%	0.7%	40%	30%	X						

Appendix 2: Overview of Direct Contracting

From a recent sell-side report on OSH:

CMS Direct Contracting expands total addressable market to all of Medicare

The emergence of CMS' new Direct Contracting models, which begins in 2021, could offer a significant revenue opportunity for Oak Street. As of the end of 3Q'20, 33% or ~30K of Oak Street's patients were in traditional Medicare (fee-for-service) yet comprised less than 3% of Oak Street's revenue. For traditional Medicare patients, Oak Street generates revenue based only on volume of services provided, as compared to capitated payments for risk-based MA patients. Under the Direct Contracting model, Oak Street has the opportunity to receive capitated payments for these traditional Medicare beneficiaries, similar to that of MA plans. The opportunity with Direct Contracting is to move from a volume-based fee-for-service reimbursement model to a value-based model in which the company is able to generate significantly more revenue per patient while also driving more consistent interaction and patient engagement but overall lower total medical costs for Medicare.

In 2012 CMS introduced The Primary Cares Initiative, which offered five new alternative payment models for primary care physicians. These models are technically under traditional fee-for-service Medicare but utilize characteristics that have been successful under MA, the Medicare Share Shared Savings Program (MSSP), and Next-Generation Accountable Care Organizations (NGACO). CMS has designed these models to reduce administrative burdens so providers can spend more time with patients to provide higher quality care and lower healthcare costs.

The Primary Care Initiative models fall under two key pathways: (1) Primary Care First and (2) Direct Contracting. Under the Primary Care First pathway there are two models: (a) general and (b) high-needs population models. Under the Direct Contracting pathway there are three models: (a) professional (50% at-risk); (b) global (100% at-risk); and (c) geographic. Oak Street will organize its DCE under the global model, which means that it will take on 100% of the risk for managing patient care with the capitated payment from CMS.

Oak Street is focused on participating in the Direct Contracting program, under which Oak Street would register as a direct contract entity (DCE) which manages care for Medicare beneficiaries in return for a capitated payment from CMS, similar to MA models. The professional, global, and geographic models differ in the level of services and risk that the DCE takes on for the patients it manages under the program.

Assuming Oak Street is able to transition its traditional Medicare patients, which totaled ~30K at the end of 3Q'20 (33% of all Oak Street patients) to Direct Contracting, and generate $12,000 in revenue per patient, Oak Street's current revenue opportunity within its existing customer base is $368 million. This compares to Oak's current annualized revenue run-rate for this population of $24 million.

With respect to the accounting for the Direct Contracting program, there are two methods by which patients can enroll into Direct Contracting: through voluntary alignment or claims-based alignment. Essentially, under voluntary alignment a patient chooses Oak Street to be its direct contractor, and under claims-based alignment a patient is assigned to Oak Street as its direct contractor if a plurality of the patient's historical primary care claims were with Oak Street. From an economics perspective, revenue is expected to be higher for voluntarily aligned patients as compared to MA patients, and revenue is expected to be lower for claims-based alignment as compared to MA patients. Claims-based enrollees will generate lower revenue because they were historically managed by Oak Street and on average should have lower levels of patient expenditures than the average Medicare patient. With respect to profitability, voluntarily aligned patients should be similar to MA patients, while claims-based aligned patients should be less profitable than voluntarily aligned and

MA patients but greater than traditional Medicare patients.
Oak Street's expectations are that a large majority of traditional Medicare patients will voluntarily align with Oak Street; however, some of these patients may end up enrolling into a MA during open enrollment periods and thus not be included in the DC program. Additionally, at the beginning of year 1, Oak Street expects slightly more voluntarily aligned patients. In future years, Oak Street expects patient mix is heavily skewed toward voluntarily aligned patients as most new patients entering the DC program will be new to Oak Street.

Figure 16: Overview of key differences between voluntary alignment and claims-based alignment in Medicare's Direct Contracting program.

	Voluntary alignment	Claims-based alignment	Key difference
Overview	Patients choose Oak Street as their DCE. After 1-2 years, voluntarily aligned patients will convert to claims-based aligned patients for accounting purposes.	Patients are assigned to Oak Street as their DCE if Oak Street represented a plurality of the patient's primary care claims within the two-year alignment "look back" period.	Voluntary alignment is chosen by patient, claims-based alignment is dictated by historical utilization.
Benchmarking used to determine per patient revenue	Blended average of regional rates multiplied by the patient's risk score.	Blended average of regional rates, adjusted for the patient's historical baseline expenditures, and then multiplied by the patient's risk score.	Claims-based alignment incorporates a patient's historical spending.
Per patient revenue	Expected to be slightly higher than MA at-risk per patient revenue	Expected to be lower than voluntarily aligned patients (Oak Street's past investments will generally have resulted in lower historical patient expenditures for claims-based patients).	Voluntary alignment should provide greater revenue per patient.
Medical costs	Higher than MA patients because DC offers traditional Medicare open access benefits.	Higher than MA patients because DC offers traditional Medicare open access benefits.	Both should have higher costs than MA.
Patient economics	Similar to MA patient economics	Lower than voluntarily aligned patients but higher than traditional Medicare patient economics	Claims-based alignment should be less profitable than voluntary alignment.

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