Attachment 1 - Letter of Intent to Apply Form

1.	Appli	Applicant's Legal Entity name: Cascade Health Allicance, LLC			
2.	Applicant's Secretary of State Business Registration ¹ : 845434-96				
3.	Orego	on Headquarter Location:	2909 Daggett Avenu	2909 Daggett Avenue, Suite 225 - Klamath Falls, OR 97601	
1.	Principle Place of Business (if different than Oregon Headquarter Location): Same				
5.	Key C	Contact Person:	Annette Fowler		
	Key Contact Person Phone/Email:		(541) 851-2080	AnnetteF@cascadecomp.com	
			Phone	Email	
5.	To be each i		nust be one (or more) of	the following (Please check yes or no for	
	a.	contractor or health insurance company from the Oregon Department of Consumer and Busine Services (DCBS), and (2) issues health benefit plans, as defined in 743B.005, in Oregon.			
		Yes No			
		If you selected Yes, please provide the DCBS Certificate of Authority number:			
	b.	b. An organization that is under, or during the last two years was under, a Medicaid contract with OHA to bear capitated health care financial risk in Oregon, including CCOs currently or formerly certified by OHA.			
		Yes No			
		If you selected Yes, please provide the Medicaid contract type and number: <u>Health Plan Services Contract #143110-11</u>			
	c. A Provider Organization which bears health care financial risk in Oregon (e.g. hospital s with capitated contracts from self-insured health plans) but which DCBS has exempted f certificate of authority by Bulletin 96-2, https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin_96-02.pdf .			ans) but which DCBS has exempted from a	
		Yes No			
		If you selected Yes, please explain the health care financial risk you bear in Oregon and how you meet the DCBS exemption:			
	d.	A Tribe or Tribal organization	on.		
		☐ Yes ■ No			
		• •	le to Applicants. Triba	e Entity or a CCO on a different timeline l members may be moved to that organization	

¹ If Applicant is formed under insurance law, furnish the registration number with the Oregon Department of Consumer and Business Services (DCBS).

e.	An entity newly formed from one or more of the organizations described above.		
	☐ Yes ■ No		
	If you selected Yes, please describe the newly formed organization and explain how the constituent or predecessor organizations meets one of the requirements in (a) through (d) above:		
Pleas	e note: Applicant's qualifications to apply will not be evaluated until after the Application due		

7. Desired Service Area

Cascade Health Alliance, LLC

County (List each desired County separately)	In your Application, will you request to serve less than the entire County?	If yes, what zip codes will be in your requested Service Area in this County?
Klamath County	Yes	97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639

Please note: If Applicant requests to cover less than a full County, it will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation and will determine whether to approve or reject the request based on criteria that include, but are not limited to, how the request better serves the goals of CCO 2.0 than serving the entire County at issue. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant's proposed Service Area based on OHA's needs and the needs of its Members. OHA may require an Applicant to accept OHA's additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members' needs warrant. Applicant's requests for Service Area will not be evaluated until after the Application due date.

- **8.** In Exhibit A, please provide an organization chart complying with the requirements of Attachment 6.
- 9. In Exhibit B, describe your current lines of health plan business in Oregon. Provide total covered lives for each line of business. (Provide separate figures for the following markets: Medicaid, other OHA, non-OHA state health plans, other state or local public sector, Medicare, other federal, Marketplace, other commercial insured, and commercial self-funded. Within each market identify numbers for benefit coverage types such as oral and comprehensive medical and identify numbers that are administrative-services-only as opposed to at-risk).

10. Applicant's Good Faith Intentions

Applicant has a good faith intention to submit an Application and believes it has the resources to do so. If at any time prior to or upon the Application due date Applicant determines it will not submit an Application, Applicant will submit to OHA a notarized letter, withdrawing this letter of intent and briefly stating the reason for the withdrawal. If at any time prior to seven days before the Application due date Applicant determines it must change the provisions of this LOI other than the requested Service Area, Applicant will submit to OHA a notarized letter, changing this letter of intent and briefly stating the reason for the change.

11. Acknowledgements

Applicant acknowledges that this Letter of Intent is binding upon Applicant if it proceeds to submit an Application and continues through the RFA process without withdrawing its Application. Applicant also acknowledges that OHA will publicly post the information in this LOI prior to the Application submission date. To be considered for a CCO Contract, Applicant must submit all required document in the RFA by the applicable dates in Section 1.2 of the RFA.

Representatives of Applicant have read the RFA in its entirety. By submitting this Letter of Intent, Applicant acknowledges and agrees to be bound by RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims). Applicant also agrees to be bound by all the other provisions of the RFA, subject to Applicant's protest rights as set forth in the RFA.

12. Signature

The signature must be notarized, as follows

- I, <u>Eyitayo "Tayo" Akins</u>, being first duly sworn under oath, and representing Applicant, hereby depose and swear or affirms under penalty of perjury that:
- a. I am an officer of the Applicant,
- b. I have personal knowledge of this Letter of Intent and believe it to be accurate, and
- c. I have full authority from the Applicant to submit this Letter of Intent.

Eyitayo "Tayo" Akins Signature	Eyitayo Akins, President & CEO Printed Name and Title	130 200 Date
State of Oregon) ss: County of Kharath)	OFFICIAL STAMP LAUREL DIANE DUFFUS NOTARY PUBLIC-OREGON COMMISSION NO. 971597 VY COMMISSION EXPIRES FEBRUARY 11. 2022	
Signed and sworn to before me on 1-30-2019	9 (date) by Exitago Akinc	(Affiant's name).
Laurel Priane Duff	us	
Notary Public for the State of Ocesor	J 	
My Commission Expires: 2-11-2022		

EXHIBIT A: ORGANIZATION CHART

Cascade Comprehensive Care, Inc.

- Parent and ultimate controlling entity
- 100% ownership of Applicant

Cascade Health Alliance, LLC

- Applicant
- Has no subsidiaries

EXHIBIT B: OREGON HEALTH CARE BUSINESS

Describe your current lines of health plan business in Oregon. Provide total covered lives for each line of business. (Provide separate figures for the following markets: Medicaid, other OHA, non-OHA state health plans, other state or local public sector, Medicare, other federal, Marketplace, other commercial insured, and commercial self-funded. Within each market identify numbers for benefit coverage types such as oral and comprehensive medical and identify numbers that are administrative-services-only as opposed to at-risk).

Cascade Health Alliance (CHA) has one line of business, Medicaid, with four benefit coverage types: CCOA, CCOB, CCOE, CCOG. These benefit types cover a total of 23,475 unique lives January through December 2018, and the forms of coverage for each benefit type is detailed in the table below:

Line of Business	Total Covered Lives	Market	Coverage
CCOA	21,923	Medicaid	Medical, Dental, Behavioral
CCOB	69	Medicaid	Medical, Behavioral
CCOE	8	Medicaid	Behavioral
CCOG	1,475	Medicaid	Dental, Behavioral