Providence Health Assurance
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com/OHP

February 15, 2019

Tammy L. Hurst OCAC, OPBC, SPC
635 Capitol Street, NE Room 350
Salem, Oregon 97301

Delivered via email to rfa.cco2.0@dhsoha.state.or.us

Dear Ms. Hurst:

Attached please find Providence Health Assurance's Change Request to the Letter of Intent to Apply for RFA OHA-4690-19, COORDINATED CARE ORGANIZATIONS 2.0.

Providence Health Assurance is requesting two changes: (1) a change to the applicant legal entity, and (2) a change to the desired service area.

The legal entity change requires revisions to Sections 1, 2, 3, 6(a), 6(b), 6(e), and Exhibit A to change the applicant from Providence Health Assurance to Providence Care, LLC, a newly formed wholly owned subsidiary of Providence Health Assurance.

The service area change requires revisions to Section 7, Desired Service Area to remove Multnomah, Washington, and Clackamas counties.

Per RFA Section 3.2(b), the justification why the change was not reflected in the original LOI is the following: (1) Providence Health Assurance created Providence Care, LLC to meet all statutory requirements to operate as a CCO, and (2) Providence Health Assurance's Letter of Intent for Multnomah, Washington, and Clackamas counties was filed as a second option to Providence's continued participation in Health Share of Oregon CCO, and that second option is no longer needed.

Sincerely,

Jonathan Cascino

Medicaid Program Director
Providence Health Plan
3601 SW Murray Blvd Ste 10
Beaverton, OR 97005

Attachment 1 - Letter of Intent to Apply Form

1. Applicant's Legal Entity name: Providence Care, LLC

2. Applicant's Secretary of State Business Registration[1]: 1526629-96

3. Oregon Headquarter Location: 4400 NE Halsey Street

4. Principle Place of Business (if different than Oregon Headquarter Location): N/A

5. Key Contact Person: Jonathan Cascino

   Key Contact Person Phone/Email: 503-574-7804 (Phone) Jonathan.Cascino@Providence.org (Email)

6. To be eligible to apply, Applicant must be one (or more) of the following (Please check yes or no for each item):

   a. An organization that (1) has a certificate of authority in good standing as a health care service contractor or health insurance company from the Oregon Department of Consumer and Business 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. 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:

   _____

   c. A Provider Organization which bears health care financial risk in Oregon (e.g. hospital systems with capitated contracts from self-insured health plans) but which DCBS has exempted from a certificate of authority by Bulletin 96-2, https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin_96-02.pdf.

   ☐ 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.

   ☐ Yes ☒ No

   Note: A Tribe may sponsor an Indian Managed Care Entity or a CCO on a different timeline from that generally applicable to Applicants. Tribal members may be moved to that organization when it is approved by OHA.

[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.

[X] 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:

Providence Care, LLC is a newly formed subsidiary of Providence Health Assurance. Providence Health Assurance meets 6a and 6b (DCBS Certificate of Authority number 956520 and Health Plan Services Contract Coordinated Care Organization Contract #143115-10)

Please note: Applicant's qualifications to apply will not be evaluated until after the Application due date.

7. Desired Service Area

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?
Hood River Clatsop Jackson	No No No	N/A N/A N/A

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, Michael Cotton, 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.

Signature	Michael Cotton, President & CEO Printed Name and Title	2/15/19 Date

State of Oregon)
) ss:
County of Multnomah

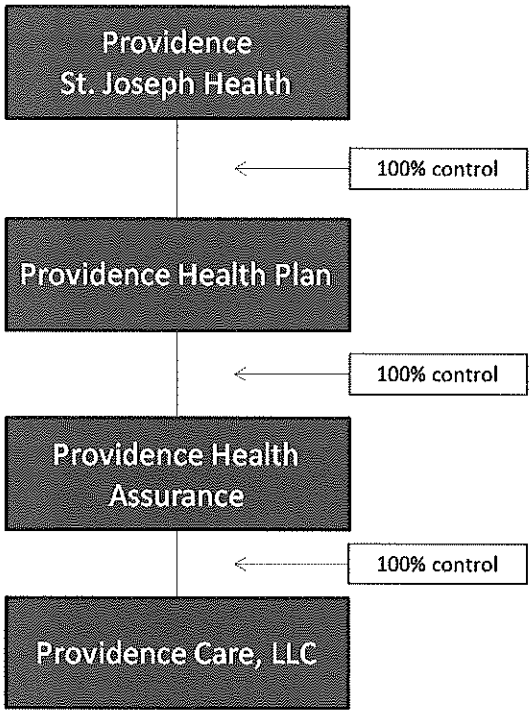
Signed and sworn to before me on 2/15/19 (date) by Michael Cotton (Affiant's name).

Notary Public for the State of Oregon
My Commission Expires: March 25, 2019

Carol Strong Brandt
Carol Strong Brandt

OFFICIAL STAMP
CAROL STRONG BRANDT
NOTARY PUBLIC-OREGON
COMMISSION NO. 937574
MY COMMISSION EXPIRES MARCH 25, 2019

EXHIBIT A: ORGANIZATION CHART
EXHIBIT B: OREGON HEALTH CARE BUSINESS



Providence Health Assurance serves 53,489 Oregon Health Plan (and Cover All Kids) beneficiaries as a physical health risk accepting entity of Health Share of Oregon Coordinated Care Organization.
Providence Health Assurance also serves 54,311 Medicare beneficiaries through numerous Medicare Advantage and Part D contracts, including 951 dual eligible beneficiaries through a Dual Eligible Special Needs Plan.
Providence Health Plan, Providence Health Assurance's parent organization, serves Oregonians through fully insured large group, small group, and individual and family plans, as well as self-funded ASO plans including PEBB.
Total covered lives for Providence Health Plan broken down by each line of business are as follows:
ASO: 164,530 (including 95,481 covered lives for PEBB)
Large Group: 76,492
Small Group: 59,581
Individual: 72,635