DELEGATION OF CREDENTIALING AGREEMENT

This Delegation of Credentialing Agreement (this "Agreement") is made and entered into to be effective as of the August 1, 2023 ("Effective Date") by and between the County of Ventura, owner and operator of Ventura County Medical Center and Santa Paula Hospital("PROVIDER") and Align Senior Care California, Inc. ("Company") for the purpose of setting forth the terms and conditions under which Company confirms and evidences its delegation of credentialing and re-credentialing responsibilities of certain health care providers employed by or under contract with PROVIDER who has agreed to provide services to Members ("Members").

RECITALS

WHEREAS, Company operates a health plan and arranges a network of providers to make available health care services to persons ("Members") enrolled in health benefit plans administered by Company;

WHEREAS, Providers who desire to provide medical services to Members must be credentialed for participation in the Health Plans;

WHEREAS, Company and PROVIDER have entered into a certain **Physician Participation Agreement**, effective August 1, 2023 (the "Services Agreement") whereby PROVIDER participating under the Services Agreement agreed to provide certain Covered Services to Members;

WHEREAS, Company wishes to delegate to PROVIDER the responsibility to credential and re-credential Professional Providers; and

WHEREAS, Company and PROVIDER hereby enter into this Agreement whereby Company and PROVIDER set forth provisions related to PROVIDER's responsibility to credential and re-credential Providers.

NOW THEREFORE, for and in consideration of the mutual covenants and agreements contained herein, the parties agree as follows:

I. Delegated Activities.

Company hereby confirms its delegation to PROVIDER and PROVIDER confirms its acceptance of the delegation from Company of the following activities:

1. Credentialing and re-credentialing of Providers, to include specifically the following elements:

    a. License to practice

    b. Hospital privileges

    c. Board certification/training

    d. Malpractice claims history

e. Malpractice insurance

f. NPDB query

g. Licensure Sanctions

h. Medicare/Medicaid sanctions

i. OIG and EPLS/SAMS

j. Medicare Opt-Out

k. DEA Participation

l. Application processing

2. Office site visit only as required per NCQA

3. Collection of performance monitoring information used in the re-credentialing process as specified by current Centers for Medicare and Medicaid Services (CMS), Utilization Review Accreditation Commission (URAC), National Committee for Quality Assurance (NCQA) and/or state specific standards.

II. Responsibilities of PROVIDER.

4. PROVIDER shall be responsible, either directly or through its certified credentials verification organization, for performing primary source verification of each provider's application, including: education and training, current professional licensure, clinical privileges in good standing at a participating hospital as applicable to provider's specialty or appropriate coverage through a hospitalist, medical board certification and/or recertification (when applicable), or next highest level of training or Educational Commission for Foreign Medical Graduates ("ECFMG"), if not certified. PROVIDER must query the National Practitioner Data Bank ("NPDB") in accordance with NPDB guidelines, rules and regulations. PROVIDER will maintain in its credentialing records copies of the provider's state license, federal Drug Enforcement Agency and appropriate State Department of Health controlled substances licenses, and medical malpractice insurance coverage obtained in its activities.

5. In performing their duties hereunder, the parties agree to comply with the standards of the Center for Medicare and Medicaid Services (CMS), URAC and NCQA and such other agreed upon accrediting bodies and such licensing authorities as may have jurisdiction, along with all other applicable local, state and federal statutes, rules and regulations.

6. PROVIDER agrees that Company or designated Credentialing Verification Organization (CVO) acting on Company's behalf, may audit PROVIDER's compliance with the credentialing program on an annual basis beginning on the Effective Date of this Agreement or on a more frequent basis as both parties

mutually agree. Such audit shall be conducted on prior written notice and during PROVIDER's regular business hours. PROVIDER shall provide Company or designated CVO access to its credentialing and re-credentialing files during such audits and permit Company to interview personnel responsible for PROVIDER's credentialing program.

7. PROVIDER agrees to develop action plans when reasonable improvement opportunities are recommended by Company.

8. PROVIDER agrees to notify Company of any material credentialing policy and procedure changes it proposes to make before the change is anticipated to take effect, except when changes are required for compliance with this delegation agreement, state law and/or accreditation standards.

9. PROVIDER agrees to supply to Company a copy of its then-current credentialing policy and plan prior to the Effective Date of this Agreement.

10. PROVIDER agrees to provide access to complete credentialing files of that are requested for review as part of Company's accreditation visit by NCQA or other regulatory body. Such access may include the transfer of files, if so permitted under PROVIDER's credentialing program, or via a virtual meeting where respective auditors can review digital files.

11. Subject to any applicable confidentiality requirements, PROVIDER agrees to allow onsite inspection and/ by any properly identified governmental regulatory authority/accrediting body of selected complete credentialing files maintained by PROVIDER.

12. Every three (3) years or sooner to the extent required by applicable state law or NCQA standards, PROVIDER shall re-credential each provider credentialed pursuant to this Agreement in accordance with PROVIDER's re-credentialing procedures.

13. PROVIDER shall provide, as described in Section IV below, data and information for each provider electing to participate with additions or deletions submitted on a monthly basis.

III. Responsibilities of Company.

14. Company shall oversee the credentialing primary verification process conducted by PROVIDER through annual on-site visits on a mutually agreed upon date and time. Company's internal quality committee shall review the audit findings, make recommendations for improvements, when necessary, and review all action plans and follow-up activities.

15. Company reserves the right to refuse to approve new providers and to terminate, disapprove, or suspend any providers from providing Covered Services to Members

if any new or existing providers fail, in the reasonable opinion of Company, to satisfy the PROVIDER credentialing standards.

16. Company shall immediately notify PROVIDER of any termination, disapproval, or suspension of any providers.

17. Company will keep all information relating to or obtained as a part of PROVIDER's credentialing activities confidential, except as required by law. PROVIDER will not be required to disclose any information if such disclosure would constitute a waiver of the confidential or privileged nature of such information.

18. Upon request by PROVIDER, Company will provide to PROVIDER quality information and such other information specifically related to PROVIDER and its providers as PROVIDER may reasonably request for the purpose of re-credentialing Providers.

IV. Reporting Requirements.

PROVIDER agrees to provide Company promptly the following reports and notice of the following events:

19. Monthly/ Quarterly report from PROVIDER listing:

    a. Updated provider data sheets/ Add, Change, Term (ACT) Files. Monthly

    b. Names of all active credentialed providers with credentialing approval dates. Quarterly

20. Notification of the closure of a provider's practice. Monthly

V. Compliance with CMS Requirements: Medicare Advantage Requirements for Delegated Activities are as follows:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA organization on an ongoing basis.

4. Each and every contract must specify that either—
    a. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization; or

b. The credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

c. The delegation agreement must also contain a provision requiring that any services or other activity performed by the delegate are compliant with the MA organization's contractual obligations, Medicare laws, regulations, and CMS instructions.

VI. Term and Termination and Assignment

1. This Agreement shall terminate on the earlier of the termination of the Services Agreement, or either party gives the other at least sixty (60) days' prior written notice of termination.

2. Either party may terminate this Agreement if the other party breaches any material part of this Agreement, upon at least thirty (30) days prior written notice; provided that such breach is not cured within such notice period.

3. Company reserves the right to revoke the delegation if PROVIDER is unable to meet Company's requirements and credentialing standards as set forth in the Group Provider Agreement after reasonable prior notice and opportunity to comply is given to PROVIDER by Company.

4. Company may immediately terminate this Agreement upon notice to PROVIDER in the event PROVIDER fails to comply to the satisfaction of Company with any corrective action plan to correct deficiencies or compliance problems.

5. Assignment. Except as otherwise provided, neither this Agreement nor any of the rights or obligations hereof may be assigned or transferred by PROVIDER without the prior written consent of Payor. Payor shall have the right, in its sole discretion, to assign this Agreement to any affiliated entity, parent, or subsidiary of Payor. PROVIDER agrees to participate, on the same terms and conditions set forth herein, with any affiliated entity, parent, or subsidiary of Payor.

VII. Representations

1. Each party hereby represents to the other party that:

   a. It is in good standing under applicable laws and regulations governing its existence and operations and that it is in compliance with and shall continue to comply with all federal, state and local laws and regulations now existing or hereafter enacted or promulgated that relate to the subject matter of this Agreement or the duties and obligations hereunder; and

   b. This Agreement has been executed by its duly authorized representative.

VIII. Miscellaneous.

1. This Agreement shall be construed and enforced pursuant to the laws of the State of California**.** Venue for any and all disputes arising under or relating to this Agreement shall be in Ventura County.

2. This Agreement can only be amended upon the signed written consent of both parties.

3. Except as expressly provided herein, neither party may assign or delegate its rights, duties and obligations hereunder without the prior written consent of the other party.

4. In performing the services hereunder, it is expressly understood and agreed that PROVIDER and Company, and any of each party's respective employees, officers, directors or representatives are at all times acting as independent contractors. Except as expressly provided in this Agreement, neither party will for any purpose be deemed to be an agent, ostensible or apparent, or servant of the other party.

5. Whenever, under the terms of this Agreement, notice is required or permitted to be given by either party to the other party, such notice shall be deemed to have been sufficiently given if sent by confirmed facsimile, personally delivered, or if deposited in the United States mail in a properly stamped envelope, certified mail return receipt requested, addressed to the party to whom it is to be given at the address set forth below:

PROVIDER:	County of Ventura 5851 Thille Street, L#4625 Ventura, CA 93003 Attn: HCA Director
With copy to:	Ventura County Medical Center 300 Hillmont Ave, 3rd Floor- Vintage Building Ventura, CA 93003 Attn: Credentialing Department
Company:	Align Senior Care 10900 Nuckols Road; Suite 110 Glen Allen, VA 23060 Attention: Credentialing Department

IX. Roles and Responsibilities Exhibit.

1. For clarity of roles and responsibilities, PROVIDER and Company agree that responsibilities for credentialing of individual providers shall align as follows:

Element	Sub-Element	Provider	Company
Credentialing Program Structure	Credentialing program policies identify: • Goals and objectives • Roles and responsibilities of credentialing committee(s) • Scope of health care practitioners credentialed and recredentialed for participation in the network who provide covered health services to members • Annual program review and approval cycle, with updates as needed	**X**	
Credentialing Committee and Governing Body	The Credentialing Committee: • Reviews established criteria for participating provider participation. • Reviews the credentialing application prior to any applicant's designation as a participating health care practitioner. • The Governing Body has final authority to approve or disapprove credentialing applications.	**X**	
Initial Credentialing	The organization performs initial credentialing of its health care professionals in accordance with applicable state and federal laws, regulations, accreditation standards, CMS instructions, and PLAN's standards, and maintains current and complete files at all times.	**X**	
Recredentialing	The organization recredentials each participating health care provider at least every three (3) years. Recredentialing is done in accordance with applicable state and federal laws, regulations, accreditation standards, CMS instructions, and PLAN's standards. Maintains current and complete files at all times. Recredentialing: • Verifies through primary or secondary source verification the information that is subject to change from initial credentialing. • Considers information regarding the participating provider's performance. Requires an application with updated and recent information on the provider's record.	**X**	
Primary Source Verification	Primary source verifications are done according to CMS and NCQA guidelines.	**X**	
Ongoing Monitoring OIG	The organization performs ongoing monitoring of providers against the OIG list and terminates any providers excluded from federal reimbursement.	**X**	**X**

Element	Sub-Element	Provider	Company
Ongoing Monitoring Participation	The organization performs ongoing monitoring of NPDB alerts, provider license, DEA and grievances against providers on a monthly basis and notifies the PLAN of any providers whose credentialing status has changed. The organization has mechanisms to consider information collected regarding the participating provider's performance.	**X**	
Ongoing Monitoring Preclusion List Review	The organization reviews providers against the CMS Preclusion list and terminates any providers identified on the list.		**X**
Ongoing Monitoring Medicare Opt Out Review	The organization reviews providers against the Medicare Opt Out.	**X**	**X**
Credentialing Confidentiality	The credentialing program ensures the confidentiality of credentialing information and limits access to credential files to authorized personnel only.	**X**	
Notification of Credentialing Decision	The organization notifies providers of the credentialing decision within 30 calendar days of the decision date or within a time frame that complies with applicable laws and regulations, whichever is less.	**X**	
Credentialing Delegation Oversight	The organization annually reviews delegate's credentialing policies and procedures and overall credentialing process.		**X**

Signature Page to Follow

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date above.

Payer

By:_____

Name:_____

Title:_____

Date:_____

PROVIDER

By:_____

Name: Barry L. Zimmerman

Title: HCA Director

Date:_____

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