AMENDMENT FOUR TO THE CONTRACT BETWEEN OKLAHOMA HEALTH CARE AUTHORITY AND AETNA BETTER HEALTH OF OKLAHOMA, INC.

The Oklahoma Health Care Authority (OHCA) and Aetna Better Health of Oklahoma, INC. (hereinafter referred to as Contractor) mutually consent to modify the language of the Agreement associated with Purchase Order number 8079004725 as enumerated below.

The following sections will be replaced with the below language.

1. **Section 1.8.6.3 Timeliness Standards**

Standard Authorizations

The Contractor shall decide standard Prior Authorization requests as expeditiously as the SoonerSelect Enrollee's health requires and not to exceed seventy-two (72) Hours following receipt of the request for service.

If the Enrollee requests an extension, or if the necessary documentation is not provided to the CE by the provider within the standard timeframe, an extension period is granted to allow the Contractor up to fourteen (14) additional Calendar Days to obtain the necessary documentation and to issue the notice of determination to the provider.

For prior authorization requests for Private Duty Nursing or State Plan Personal Care that are submitted when the Enrollee is outpatient, the Contractor must make a determination within seventy-two (72) Hours but is granted an extension of fourteen (14) additional Calendar Days to issue a determination when the Contractor does not have the all necessary documentation and completed assessments to make a decision within the seventy-two (72) Hour timeframe.

For all standard authorizations, if an extension is granted that was not requested by the Enrollee, and the extension duration exceeds forty-eight (48) Hours beyond the standard timeliness requirement for the authorization type, the Contractor shall provide the Enrollee with a written explanation and information on how an Appeal may be filed in response to the extension in accordance with 42 C.F.R. § 438.404(c)(4). Furthermore, extension requests requested by the Contractor and not requested by an Enrollee or Provider acting as Authorized Representative of the Enrollee, are subject to a request for justification by OHCA where the Contractor must justify the need for additional information and must justify how the extension is the Enrollee's best interest.

Any authorization type not referenced in the forthcoming Expedited Authorization / Special Handling guidance in 1.8.6.3 is considered a standard authorization.

Expedited Authorizations and other Special Handling

If the Provider indicates, or the Contractor is aware, that adhering to the standard seventy-two (72) Hour time frame could jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an authorization decision as expeditiously as necessary, and in no event, later than twenty-four (24) Hours after receipt of the request for service. Such expedited authorizations include prior authorization requests for Urgent Care.

For an expedited authorization, if the Enrollee requests an extension, or the necessary documentation is not provided to the CE by the provider within the standard timeframe, an extension period is granted to allow the Contractor an additional forty-eight (48) Hours to obtain the necessary documentation and to issue the notice of determination to the provider.

Notwithstanding the foregoing, all Acute Inpatient Behavioral Health prior authorization requests must be decided within twenty-four (24) Hours with no allowance for extension.

For authorizations pertaining to Inpatient Behavioral Health in the Acute II/Psychiatric Residential Treatment Facility category, when possible, the Contractor should make a determination and issue notice to the provider within twenty-four (24) Hours of receipt of the request. However, if the necessary documentation is not provided to the Contractor by the provider within the standard timeframe, an extension period is granted to allow the Contractor an additional forty-eight (48) Hours to obtain the necessary documentation and to issue notice of determination to the provider.

When the Enrollee is inpatient at the time of a prior authorization request, Contractor should make a determination and issue notice to the provider within twenty-four (24) Hours of receipt of request. However, if the necessary documentation is not provided to the Contractor by the provider within the standard timeframe, an extension period is granted to allow the Contractor an additional forty-eight (48) Hours to obtain the necessary documentation and to issue notice of determination to provider. This inpatient requirement includes authorization requests for inpatient acute medical or post-acute medical services, as well as outpatient requests not otherwise specified in 1.8.6.3.

For prior authorization requests for Private Duty Nursing or State Plan Personal Care that are submitted when the Enrollee is inpatient, the Contractor must make a determination within twenty-four (24) Hours when clinically warranted, but is granted an extension of fourteen (14) additional Calendar Days to issue a determination if the Contractor does not have the all necessary documentation and completed assessments to make a decision within the twenty-four (24) Hour timeframe.

For all expedited authorizations, if an extension is granted that was not requested by the Enrollee, and the extension duration exceeds forty-eight (48) Hours beyond

the standard timeliness requirement for the authorization type, the Contractor shall provide the Enrollee with a written explanation and information on how an Appeal may be filed in response to the extension in accordance with 42 C.F.R. § 438.404(c)(4). Furthermore, extension requests requested by the Contractor and not requested by an Enrollee or Provider acting as Authorized Representative of the Enrollee, are subject to a request for justification by OHCA where the Contractor must justify the need for additional information and must justify how the extension is the Enrollee's best interest.

2. Section 1.18.6.6 Prior Authorization Denial or Limitation

In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d), when the action for which the notice of Adverse Benefit Determination is being provided is (a) a "Standard authorization decision[]" under 42 C.F.R. § 438.210(d)(1) to deny or limit services, the Contractor shall provide the notice as expeditiously as the enrollee's condition requires and no later than seventy-two (72) Hours following receipt of request. Following the extension timeframes stated in 1.8.6.3, the Contractor may extend notice timeframe up to an additional fourteen (14) Calendar Days if:

a. The Enrollee or a Provider acting as Authorized Representative of the Enrollee requests an extension; or

b. The Contractor, if OHCA requests justification, demonstrates a need for additional information and how the extension is in the Enrollee's interest.

If the Contractor utilizes the extension for a need of additional information, the Contractor is subject to both the OHCA request for justification and the requirement to provide notice to the member no later than forty-eight (48) Hours after the prior authorization is extended as described in 1.8.6.3.

3. Section 1.18.6.7 Expedited Prior Authorization Denial

In accordance with 42 C.F.R. §§ 438.404(c)(6) and 438.210(d)(2), and in cases in which a Provider indicates or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the Enrollee's life, health, or Enrollee's ability to attain, maintain, or regain maximum function, the Contractor shall expedite the authorization decision and provide notice as expeditiously as the Enrollee's health condition requires no later than twenty-four (24) Hours after receipt of the request for service. Notice and decision for all expedited authorizations shall be subject to the initial twenty-four (24) Hour timeframe. The Contractor shall also provide verbal and electronic communication for all expedited authorization decisions. Following the extension timeframes

stated in 1.8.6.3, the Contractor may extend the twenty-four (24) Hour time period for written notice by up to forty-eight (48) Hours if:

a. The Enrollee or a Provider acting as Authorized Representative of the Enrollee requests an extension; or

b. The Contractor, if OHCA requests justification, demonstrates a need for additional information and how the extension is in the Enrollee's interest.

If the Contractor utilizes the extension for a need of additional information, the Contractor is subject to both the OHCA request for justification and the requirement to provide notice to the member no later than forty-eight (48) Hours after the prior authorization is extended as described in 1.8.6.3.

4. Appendix 1E: Liquidated Damages

Contract Requirement	Performance Standard	Liquidated Damages
Section 1.8.6.3: "Timeliness Standards" Section 1.18.6.6: "Prior Authorization Denial or Limitation" Section 1.18.6.7: "Expedited Prior Authorization Denial"	The Contractor fails to comply with timeliness requirements for processing Prior Authorizations.	OHCA may assess a Liquidated Damages of: a. $5,000 for each calendar month the Contractor fails to adjudicate all Prior Authorization (PA) requests within seventy-two (72) Hours or within the permitted extended timeframe. b. $10,000 for each calendar month the Contractor fails to adjudicate all expedited PA requests within twenty-four (24) Hours or within the permitted extended timeframe.

5. Section 1.2.19 Insurance

The Parties agree to amend the paragraph in Section 1.2.19 Insurance regarding subcontractor insurance requirements as follows:

Original Paragraph

"The Contractor shall require that each of its Subcontractors, independent contractors, or Affiliates of those entities or individuals, maintain insurance coverage as specified in this section or, in the alternative, the Contractor may provide coverage for each Subcontractor's, independent contractor's, Agent's, or employees and Affiliates thereof, liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its Subcontractors."

Revised Paragraph

The Contractor shall require that each of its Subcontractors, independent contractors, or Affiliates of those entities or individuals, maintain insurance coverage proportional to the Subcontractor's, independent contractor's, or Affiliates' liability to the Contractor and to OHCA. The Subcontractor, independent contractor, or Affiliates must maintain insurance coverage of the type relevant to the Contract, and at minimum $1,000,000 for Professional Liability Insurance in all cases and at minimum $10,000,000 for Cyber Liability Insurance if they handle OHCA PHI or data. Alternatively, the Contractor may provide proportional coverage for the liability and employees of each Subcontractor, independent contractor, Agent, or employees and Affiliates thereof. The provisions of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its Subcontractors.

This Amendment shall be incorporated by the acceptance of both parties and effective upon signature. No other terms or provisions of the Agreement are changed or affected.

EXECUTED

Lisa Gifford

Lisa Gifford (Feb 19, 2025 08:44 CST)

Lisa Gifford, Chief Executive Officer
Aetna Better Health of Oklahoma, INC.

Ellen Buettner

Digitally signed by Ellen Buettner
Date: 2025.03.07 10:05:20 -06'00'

Ellen Buettner, Chief Executive Officer
Oklahoma Health Care Authority