

OKLAHOMA STATE SENATE
CONFERENCE
COMMITTEE REPORT

May 17, 2021

Mr. President:

Mr. Speaker:

The Conference Committee, to which was referred

SB131

By: McCortney et al of the Senate and McEntire et al of the House

Title: Public health; creating the Oklahomans Caring for Oklahomans Act; Medicaid beneficiaries.
Emergency.

_____ together with Engrossed House Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the House recede from all Amendments.
2. That the attached Conference Committee Substitute be adopted.

Respectfully submitted,

SENATE CONFEREES:

McCortney

Treat

Floyd

Thompson

Garvin

Hicks

Rosino

HOUSE CONFEREES:

Conference Committee on Public Health

Senate Action _____ Date _____ House Action _____ Date _____

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 131

By: McCortney, Garvin and Treat
of the Senate

and

McEntire, Newton, Bush,
Fugate, Pae, McDugle, Roe,
Moore, Talley, Cornwell,
Marti, Fetgatter, Culver,
Lawson, Humphrey and
Waldron of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program;
creating the "Ensuring Access to Medicaid Act";
defining terms; authorizing Oklahoma Health Care
Authority to require enrollment in certain delivery
model for certain individuals; providing for
voluntary enrollment by certain individuals;
specifying enrollment process for certain
individuals; prohibiting requirement or offer of
enrollment for certain individuals; directing
Authority to develop certain network adequacy
standards; requiring managed care organizations and
dental benefit managers to meet or exceed network
adequacy requirements; requiring contracting with
certain providers; requiring certain credentialing
and recredentialing process for providers; requiring
accreditation for managed care organizations and
dental benefit managers; requiring certain
notification for material change; requiring medical
loss ratio to meet certain standards; requiring
certain provision of patient data upon request;
prohibiting enforcement of certain policy or contract
term; prohibiting contract from disallowing certain
contract with accountable care organization;

1 stipulating timeframes for certain authorizations;
 2 providing for peer-to-peer review; requiring
 3 Authority to ensure timely offering of authorized
 4 services; setting certain requirements for processing
 5 and adjudication of claims; requiring managed care
 6 organizations and dental benefit managers to utilize
 7 certain procedures for review and appeal; directing
 8 Authority to develop certain procedures; providing
 9 requirements for appeal of adverse determination
 10 based on medical necessity; providing for fair
 11 hearing; providing for non-compliance remedies;
 12 requiring managed care organization or dental benefit
 13 manager to participate in readiness review;
 14 specifying criteria of readiness review; allowing
 15 execution of transition of certain delivery system
 16 under certain condition; directing Authority to
 17 create certain quarterly scorecard; specifying
 18 criteria of scorecard; requiring Authority to provide
 19 scorecard to enrollees and publish on its Internet
 20 website; directing Authority to establish minimum
 21 rates of reimbursement for certain providers; setting
 22 minimum rates for certain time period; requiring
 23 managed care organization or dental benefit manager
 24 to offer value-based payment arrangements to certain
 providers; requiring use of certain quality measures
 for value-based payments; directing Authority to
 comply with federally required payment methodologies;
 creating the MC Quality Advisory Committee; providing
 for duties, membership, selection of chair and vice
 chair, meetings, quorum and staff support;
 prohibiting compensation; providing for codification;
 and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified
 in the Oklahoma Statutes as Section 4002.1 of Title 56, unless there
 is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Ensuring Access
 to Medicaid Act".

1 SECTION 2. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 4002.2 of Title 56, unless there
3 is created a duplication in numbering, reads as follows:

4 As used in this act:

5 1. "Adverse determination" has the same meaning as provided by
6 Section 6475.3 of Title 36 of the Oklahoma Statutes;

7 2. "Claims denial error rate" means the rate of claims denials
8 that are overturned on appeal;

9 3. "Clean claim" means a properly completed billing form with
10 Current Procedural Terminology, 4th Edition or a more recent
11 edition, the Tenth Revision of the International Classification of
12 Diseases coding or a more recent revision, or Healthcare Common
13 Procedure Coding System coding where applicable that contains
14 information specifically required in the Provider Billing and
15 Procedure Manual of the Oklahoma Health Care Authority;

16 4. "Dental benefit manager" means an entity under contract with
17 the Oklahoma Health Care Authority to manage and deliver dental
18 benefits and services to enrollees of the capitated managed care
19 delivery model of the state Medicaid program;

20 5. "Essential community provider" has the same meaning as
21 provided by 45 C.F.R., Section 156.235;

22 6. "Managed care organization" means a health plan under
23 contract with the Oklahoma Health Care Authority to participate in
24

1 and deliver benefits and services to enrollees of the capitated
2 managed care delivery model of the state Medicaid program;

3 7. "Material change" includes, but is not limited to, any
4 change in overall business operations such as policy, process or
5 protocol which affects, or can reasonably be expected to affect,
6 more than five percent (5%) of enrollees or participating providers
7 of the managed care organization or dental benefit manager;

8 8. "Medical necessity" has the same meaning as provided by
9 rules of the Oklahoma Health Care Authority Board;

10 9. "Participating provider" means a provider who has a contract
11 with or is employed by a managed care organization or dental benefit
12 manager to provide services to enrollees under the capitated managed
13 care delivery model of the state Medicaid program; and

14 10. "Provider" means a health care or dental provider licensed
15 or certified in this state.

16 SECTION 3. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 4002.3 of Title 56, unless there
18 is created a duplication in numbering, reads as follows:

19 A. Unless expressly authorized by the Legislature, the Oklahoma
20 Health Care Authority may only require enrollment in a capitated
21 managed care delivery model of the state Medicaid program for
22 eligible individuals from an enrollee population of the state
23 Medicaid program delineated as a mandatory enrollment population in
24 the SoonerSelect Request for Proposals awarded in January of 2021 or

1 the SoonerSelect Dental Program Request for Proposals awarded in
2 February of 2021.

3 B. 1. Unless expressly authorized by the Legislature,
4 enrollment in a capitated managed care delivery model of the state
5 Medicaid program shall be voluntary for eligible individuals from an
6 enrollee population of the state Medicaid program delineated as a
7 voluntary enrollment population in the SoonerSelect Request for
8 Proposals awarded in January of 2021 or the SoonerSelect Dental
9 Program Request for Proposals awarded in February of 2021.

10 2. The Authority may only utilize an opt-in enrollment process
11 for the voluntary enrollment of individuals in the American
12 Indian/Alaska Native population.

13 C. Unless expressly authorized by the Legislature, the
14 Authority shall not:

15 1. Require enrollment in a capitated managed care delivery
16 model of the state Medicaid program for eligible individuals from
17 any enrollee population of the state Medicaid program delineated as
18 an excluded population in or omitted entirely from the SoonerSelect
19 Request for Proposals awarded in January of 2021 or the SoonerSelect
20 Dental Program Request for Proposals awarded in February of 2021; or

21 2. Offer voluntary enrollment in a capitated managed care
22 delivery model of the state Medicaid program to eligible individuals
23 from any enrollee population of the state Medicaid program
24 delineated as an excluded population in or omitted entirely from the

1 SoonerSelect Request for Proposals awarded in January of 2021 or the
2 SoonerSelect Dental Program Request for Proposals awarded in
3 February of 2021.

4 SECTION 4. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 4002.4 of Title 56, unless there
6 is created a duplication in numbering, reads as follows:

7 A. The Oklahoma Health Care Authority shall develop network
8 adequacy standards for all managed care organizations and dental
9 benefit managers that, at a minimum, meet the requirements of 42
10 C.F.R., Sections 438.14 and 438.68. Network adequacy standards
11 established under this subsection shall be designed to ensure
12 enrollees covered by the managed care organizations and dental
13 benefit managers who reside in health professional shortage areas
14 (HPSAs) designated under Section 332(a)(1) of the Public Health
15 Service Act (42 U.S.C., Section 254e(a)(1)) have access to in-person
16 health care and telehealth services with providers, especially adult
17 and pediatric primary care practitioners.

18 B. All managed care organizations and dental benefit managers
19 shall meet or exceed network adequacy standards established by the
20 Authority under subsection A of this section to ensure sufficient
21 access to providers for enrollees of the state Medicaid program.

22 C. All managed care organizations and dental benefit managers
23 shall contract to the extent possible and practicable with all
24 essential community providers, all providers who receive directed

1 payments in accordance with 42 C.F.R., Part 438 and such other
2 providers as the Authority may specify.

3 D. All managed care organizations and dental benefit managers
4 shall formally credential and recredential network providers at a
5 frequency required by a single, consolidated provider enrollment and
6 credentialing process established by the Authority in accordance
7 with 42 C.F.R., Section 438.214.

8 E. All managed care organizations and dental benefit managers
9 shall be accredited in accordance with 45 C.F.R., Section 156.275 by
10 an accrediting entity recognized by the United States Department of
11 Health and Human Services.

12 SECTION 5. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 4002.5 of Title 56, unless there
14 is created a duplication in numbering, reads as follows:

15 A. A managed care organization or dental benefit manager shall
16 promptly notify the Authority of all changes materially affecting
17 the delivery of care or the administration of its program.

18 B. A managed care organization or dental benefit manager shall
19 have a medical loss ratio that meets the standards provided by 42
20 C.F.R., Section 438.8.

21 C. A managed care organization or dental benefit manager shall
22 provide patient data to a provider upon request to the extent
23 allowed under federal or state laws, rules or regulations including,
24

1 but not limited to, the Health Insurance Portability and
2 Accountability Act of 1996.

3 D. A managed care organization or dental benefit manager or a
4 subcontractor of such managed care organization or dental benefit
5 manager shall not enforce a policy or contract term with a provider
6 that requires the provider to contract for all products that are
7 currently offered or that may be offered in the future by the
8 managed care organization or dental benefit manager or
9 subcontractor.

10 E. Nothing in a contract between the Authority and a managed
11 care organization or dental benefit manager shall prohibit the
12 managed care organization or dental benefit manager from contracting
13 with a statewide or regional accountable care organization to
14 implement the capitated managed care delivery model of the state
15 Medicaid program.

16 SECTION 6. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 4002.6 of Title 56, unless there
18 is created a duplication in numbering, reads as follows:

19 A. A managed care organization shall make a determination on a
20 request for an authorization of the transfer of a hospital inpatient
21 to a post-acute care or long-term acute care facility within twenty-
22 four (24) hours of receipt of the request.

23 B. Review and issue determinations made by a managed care
24 organization or, as appropriate, by a dental benefit manager for

1 prior authorization for care ordered by primary care or specialist
2 providers shall be timely and shall occur in accordance with the
3 following:

4 1. Within seventy-two (72) hours of receipt of the request for
5 any patient who is not hospitalized at the time of the request;
6 provided, that if the request does not include sufficient or
7 adequate documentation, the review and issue determination shall
8 occur within a time frame and in accordance with a process
9 established by the Authority. The process established by the
10 Authority pursuant to this paragraph shall include a time frame of
11 at least forty-eight (48) hours within which a provider may submit
12 the necessary documentation;

13 2. Within one (1) business day of receipt of the request for
14 services for a hospitalized patient including, but not limited to,
15 acute care inpatient services or equipment necessary to discharge
16 the patient from an inpatient facility;

17 3. Notwithstanding the provisions of paragraphs 1 or 2 of this
18 subsection, as expeditiously as necessary and, in any event, within
19 twenty-four (24) hours of receipt of the request for service if
20 adhering to the provisions of paragraphs 1 or 2 of this subsection
21 could jeopardize the enrollee's life, health or ability to attain,
22 maintain or regain maximum function. In the event of a medically
23 emergent matter, the managed care organization or dental benefit
24 manager shall not impose limitations on providers in coordination of

1 post-emergent stabilization health care including pre-certification
2 or prior authorization;

3 4. Notwithstanding any other provision of this subsection,
4 within twenty-four (24) hours of receipt of the request for
5 inpatient behavioral health services; and

6 5. Within twenty-four (24) hours of receipt of the request for
7 covered prescription drugs that are required to be prior authorized
8 by the Authority. The managed care organization shall not require
9 prior authorization on any covered prescription drug for which the
10 Authority does not require prior authorization.

11 C. Upon issuance of an adverse determination on a prior
12 authorization request under subsection B of this section, the
13 managed care organization or dental benefit manager shall provide
14 the requesting provider, within seventy-two (72) hours of receipt of
15 such issuance, with reasonable opportunity to participate in a peer-
16 to-peer review process with a provider who practices in the same
17 specialty, but not necessarily the same sub-specialty, and who has
18 experience treating the same population as the patient on whose
19 behalf the request is submitted; provided, however, if the
20 requesting provider determines the services to be clinically urgent,
21 the managed care organization or dental benefit manager shall
22 provide such opportunity within twenty-four (24) hours of receipt of
23 such issuance. Services not covered under the state Medicaid
24

1 program for the particular patient shall not be subject to peer-to-
2 peer review.

3 D. The Authority shall ensure that a provider offers to provide
4 to an enrollee in a timely manner services authorized by a managed
5 care organization or dental benefit manager.

6 SECTION 7. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 4002.7 of Title 56, unless there
8 is created a duplication in numbering, reads as follows:

9 A managed care organization or dental benefit manager shall
10 comply with the following requirements with respect to processing
11 and adjudication of claims for payment submitted in good faith by
12 providers for health care items and services furnished by such
13 providers to enrollees of the state Medicaid program:

14 1. A managed care organization or dental benefit manager shall
15 process a clean claim in the time frame provided by Section 1219 of
16 Title 36 of the Oklahoma Statutes and no less than ninety percent
17 (90%) of all clean claims shall be paid within fourteen (14) days of
18 submission to the managed care organization or dental benefit
19 manager. A clean claim that is not processed within the time frame
20 provided by Section 1219 of Title 36 of the Oklahoma Statutes shall
21 bear simple interest at the monthly rate of one and one-half percent
22 (1.5%) payable to the provider. A claim filed by a provider within
23 six (6) months of the date the item or service was furnished to an
24 enrollee shall be considered timely. If a claim meets the

1 definition of a clean claim, the managed care organization or dental
2 benefit manager shall not request medical records of the enrollee
3 prior to paying the claim. Once a claim has been paid, the managed
4 care organization or dental benefit manager may request medical
5 records if additional documentation is needed to review the claim
6 for medical necessity;

7 2. In the case of a denial of a claim including, but not
8 limited to, a denial on the basis of the level of emergency care
9 indicated on the claim, the managed care organization or dental
10 benefit manager shall establish a process by which the provider may
11 identify and provide such additional information as may be necessary
12 to substantiate the claim. Any such claim denial shall include the
13 following:

- 14 a. a detailed explanation of the basis for the denial,
15 and
- 16 b. a detailed description of the additional information
17 necessary to substantiate the claim;

18 3. Postpayment audits by a managed care organization or dental
19 benefit manager shall be subject to the following requirements:

- 20 a. subject to subparagraph b of this paragraph, insofar
21 as a managed care organization or dental benefit
22 manager conducts postpayment audits, the managed care
23 organization or dental benefit manager shall employ
24

1 the postpayment audit process determined by the
2 Authority,

3 b. the Authority shall establish a limit on the
4 percentage of claims with respect to which postpayment
5 audits may be conducted by a managed care organization
6 or dental benefit manager for health care items and
7 services furnished by a provider in a plan year, and

8 c. the Authority shall provide for the imposition of
9 financial penalties under such contract in the case of
10 any managed care organization or dental benefit
11 manager with respect to which the Authority determines
12 has a claims denial error rate of greater than five
13 percent (5%). The Authority shall establish the
14 amount of financial penalties and the time frame under
15 which such penalties shall be imposed on managed care
16 organizations and dental benefit managers under this
17 subparagraph, in no case less than annually; and

18 4. A managed care organization may only apply readmission
19 penalties pursuant to rules promulgated by the Oklahoma Health Care
20 Authority Board. The Board shall promulgate rules establishing a
21 program to reduce potentially preventable readmissions. The program
22 shall use a nationally recognized tool, establish a base measurement
23 year and a performance year, and provide for risk-adjustment based
24

1 on the population of the state Medicaid program covered by the
2 managed care organizations and dental benefit managers.

3 SECTION 8. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 4002.8 of Title 56, unless there
5 is created a duplication in numbering, reads as follows:

6 A. A managed care organization or dental benefit manager shall
7 utilize uniform procedures established by the Authority under
8 subsection B of this section for the review and appeal of any
9 adverse determination by the managed care organization or dental
10 benefit manager sought by any enrollee or provider adversely
11 affected by such determination.

12 B. The Authority shall develop procedures for enrollee or
13 providers to seek review by the managed care organization or dental
14 benefit manager of any adverse determination made by the managed
15 care organization or dental benefit manager. A provider shall have
16 six (6) months from the receipt of a claim denial to file an appeal.
17 With respect to appeals of adverse determinations made by a managed
18 care organization or dental benefit manager on the basis of medical
19 necessity, the following requirements shall apply:

20 1. Medical review staff of the managed care organization or
21 dental benefit manager shall be licensed or credentialed health care
22 clinicians with relevant clinical training or experience; and

23 2. All managed care organizations and dental benefit managers
24 shall use medical review staff for such appeals and shall not use

1 any automated claim review software or other automated functionality
2 for such appeals.

3 C. Upon receipt of notice from the managed care organization or
4 dental benefit manager that the adverse determination has been
5 upheld on appeal, the enrollee or provider may request a fair
6 hearing from the Authority. The Authority shall develop procedures
7 for fair hearings in accordance with 42 C.F.R., Part 431.

8 SECTION 9. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 4002.9 of Title 56, unless there
10 is created a duplication in numbering, reads as follows:

11 In addition to such other remedies or penalties as may be
12 prescribed by law, a managed care organization or dental benefit
13 manager found to be in violation of the provisions of or rules
14 promulgated under this act or of the terms and conditions of the
15 contract entered into between the managed care organization or
16 dental benefit manager and the Oklahoma Health Care Authority shall
17 be subject to one or more non-compliance remedies of the Authority.

18 SECTION 10. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 4002.10 of Title 56, unless
20 there is created a duplication in numbering, reads as follows:

21 A. The Oklahoma Health Care Authority shall require a managed
22 care organization or dental benefit manager to participate in a
23 readiness review in accordance with 42 C.F.R., Section 438.66. The
24 readiness review shall assess the ability and capacity of the

1 managed care organization or dental benefit manager to perform
2 satisfactorily in such areas as may be specified in 42 C.F.R.,
3 Section 438.66. In addition, the readiness review shall assess
4 whether:

5 1. The managed care organization or dental benefit manager has
6 entered into contracts with providers to the extent necessary to
7 meet network adequacy standards prescribed by Section 4 of this act;

8 2. The contracts described in paragraph 1 of this subsection
9 offer, but do not require, value-based payment arrangements as
10 provided by Section 12 of this act; and

11 3. The managed care organization or dental benefit manager and
12 the providers described in paragraph 1 of this subsection have
13 established and tested data infrastructure such that exchange of
14 patient data can reasonably be expected to occur within one hundred
15 twenty (120) calendar days of execution of the transition of the
16 delivery system described in subsection B of this section. The
17 Authority shall assess its ability to facilitate the exchange of
18 patient data, claims, coordination of benefits and other components
19 of a managed care delivery model.

20 B. The Oklahoma Health Care Authority may only execute the
21 transition of the delivery system of the state Medicaid program to
22 the capitated managed care delivery model of the state Medicaid
23 program ninety (90) days after the Centers for Medicare and Medicaid
24 Services has approved all contracts entered into between the

1 Authority and all managed care organizations and dental benefit
2 managers following submission of the readiness reviews to the
3 Centers for Medicare and Medicaid Services.

4 SECTION 11. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 4002.11 of Title 56, unless
6 there is created a duplication in numbering, reads as follows:

7 No later than one year following the execution of the delivery
8 model transition described in Section 10 of this act, the Oklahoma
9 Health Care Authority shall create a scorecard that compares managed
10 care organizations and dental benefit managers. The scorecard shall
11 report the average speed of authorizations of services, rates of
12 denials of services, enrollee satisfaction survey results and such
13 other criteria as the Authority may require. The scorecard shall be
14 compiled quarterly and shall consist of the information specified in
15 this section from the prior year. The Authority shall provide the
16 most recent quarterly scorecard to all initial enrollees during
17 enrollment choice counseling following the eligibility determination
18 and prior to initial enrollment. The Authority shall provide the
19 most recent quarterly scorecard to all enrollees at the beginning of
20 each enrollment period. The Authority shall publish each quarterly
21 scorecard on its Internet website.

22 SECTION 12. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 4002.12 of Title 56, unless
24 there is created a duplication in numbering, reads as follows:

1 A. The Oklahoma Health Care Authority shall establish minimum
2 rates of reimbursement from managed care organizations and dental
3 benefit managers to providers who elect not to enter into value-
4 based payment arrangements under subsection B of this section for
5 health care items and services furnished by such providers to
6 enrollees of the state Medicaid program. Until July 1, 2026, such
7 reimbursement rates shall be equal to or greater than:

8 1. For an item or service provided by a participating provider
9 who is in the network of the managed care organization or dental
10 benefit manager, one hundred percent (100%) of the reimbursement
11 rate for the applicable service in the applicable fee schedule of
12 the Authority; or

13 2. For an item or service provided by a non-participating
14 provider or a provider who is not in the network of the managed care
15 organization or dental benefit manager, ninety percent (90%) of the
16 reimbursement rate for the applicable service in the applicable fee
17 schedule of the Authority as of January 1, 2021.

18 B. A managed care organization or dental benefit manager shall
19 offer value-based payment arrangements to all providers in its
20 network capable of entering into value-based payment arrangements.
21 Such arrangements shall be optional for the provider. The quality
22 measures used by a managed care organization or dental benefit
23 manager to determine reimbursement amounts to providers in value-
24 based payment arrangements shall align with the quality measures of

1 the Authority for managed care organizations or dental benefit
2 managers.

3 C. Notwithstanding any other provision of this section, the
4 Authority shall comply with payment methodologies required by
5 federal law or regulation for specific types of providers including,
6 but not limited to, Federally Qualified Health Centers, rural health
7 clinics, pharmacies, Indian Health Care Providers and emergency
8 services.

9 SECTION 13. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 4002.13 of Title 56, unless
11 there is created a duplication in numbering, reads as follows:

12 A. There is hereby created the MC Quality Advisory Committee
13 for the purpose of performing the duties specified in subsection B
14 of this section.

15 B. The primary power and duty of the Committee shall be to make
16 recommendations to the Administrator of the Oklahoma Health Care
17 Authority and the Oklahoma Health Care Authority Board on quality
18 measures used by managed care organizations and dental benefit
19 managers in the capitated managed care delivery model of the state
20 Medicaid program.

21 C. 1. The Committee shall be comprised of members appointed by
22 the Administrator of the Oklahoma Health Care Authority. Members
23 shall serve at the pleasure of the Administrator.
24

1 2. A majority of the members shall be providers participating
2 in the capitated managed care delivery model of the state Medicaid
3 program, and such providers may include members of the Advisory
4 Committee on Medical Care for Public Assistance Recipients. Other
5 members shall include, but not be limited to, representatives of
6 hospitals and integrated health systems, other members of the health
7 care community, and members of the academic community having
8 subject-matter expertise in the field of health care or subfields of
9 health care, or other applicable fields including, but not limited
10 to, statistics, economics or public policy.

11 3. The Committee shall select from among its membership a chair
12 and vice chair.

13 E. 1. The Committee may meet as often as may be required in
14 order to perform the duties imposed on it.

15 2. A quorum of the Committee shall be required to approve any
16 final action of the Committee. A majority of the members of the
17 Committee shall constitute a quorum.

18 3. Meetings of the Committee shall be subject to the Oklahoma
19 Open Meeting Act.

20 F. Members of the Committee shall receive no compensation or
21 travel reimbursement.

22 G. The Oklahoma Health Care Authority shall provide staff
23 support to the Committee. To the extent allowed under federal or
24 state law, rules or regulations, the Authority, the State Department

1 of Health, the Department of Mental Health and Substance Abuse
2 Services and the Department of Human Services shall as requested
3 provide technical expertise, statistical information, and any other
4 information deemed necessary by the chair of the Committee to
5 perform the duties imposed on it.

6 SECTION 14. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 4004 of Title 56, unless there
8 is created a duplication in numbering, reads as follows:

9 A. The Oklahoma Health Care Authority shall seek any federal
10 approval necessary to implement this act.

11 B. The Oklahoma Health Care Authority Board shall promulgate
12 rules to implement this act.

13 SECTION 15. This act shall become effective September 1, 2021.

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