SENATE FLOOR VERSION
February 9, 2026

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1645 By: Gollihare of the Senate

and

Lawson of the House

[state Medicaid program - audits - appeals process - judicial review - recoupment of funds - promulgation of rules - codification - 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 5051.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Audit" means any review, analysis, or investigation conducted by the Oklahoma Health Care Authority, a contracted entity, or an entity on behalf of the Authority or the contracted entity, of a Medicaid claim submitted by a provider if the review, analysis, or investigation:

a. may result in recoupment, withholding, denial, or adjustment of Medicaid payments, and

b. involves records, documents, or information other than the filed claim;

2. "Capitated contract" and "contracted entity" have the same meanings as provided by the Ensuring Access to Medicaid Act, Section 4002.2 of Title 56 of the Oklahoma Statutes;

3. "Clerical or recordkeeping error" means a mistake or an omission in the filed claim regarding a required document or record. A clerical or recordkeeping error includes, but is not limited to, a:

a. typographical error,

b. scrivener's error, or

c. computer error; and

4. "Provider" means any health care provider or behavioral health provider that is contracted with the Authority or a contracted entity to provide services to members of the state Medicaid program.

B. Subject to applicable federal law, when the Oklahoma Health Care Authority or a contracted entity conducts an audit of a Medicaid provider, the audit shall be conducted according to the following requirements and procedures:

1. The Authority or the contracted entity shall give the provider notice of the audit at least one (1) week before conducting the initial audit for each audit cycle;

2. a. An audit that involves the application of clinical or professional judgment shall be conducted in

consultation with any state agency that licenses, contracts with, or oversees the provider.

b. The Authority or the contracted entity shall not cite a provider that is contracted with a state agency other than the Authority for delivery of Medicaid services for an error based on an act or omission that complied with applicable rules, policies, or guidance of such state agency;

3. a. A clerical or recordkeeping error shall not:

(1) constitute fraud, or

(2) be subject to criminal penalties without proof of intent to commit fraud.

b. A claim arising under subparagraph a of this paragraph may be subject to recoupment;

4. Submission of a corrected claim by a provider shall not constitute an admission of liability, fault, or wrongdoing;

5. a. When an audit is for a specifically identified problem that has been disclosed to the provider, the audit shall be limited to a claim that is identified by a claim number.

b. For an audit other than that described in subparagraph a of this paragraph, the audit shall be limited to the greater of:

(1) fifty claims, or

(2) twenty-five one-hundredths percent (0.25%) of the number of claims billed by the provider to the auditor in the previous calendar year.

c. If an audit reveals the necessity for a review of additional claims, the audit shall be conducted by one of the following methods at the discretion of the provider:

(1) on-site,

(2) electronically, or

(3) by the same method as the initial audit.

d. Except for an audit initiated under subparagraph a of this paragraph, the Authority or the contracted entity shall not initiate an audit of a provider more than two (2) times in a calendar year;

6. A recoupment shall not be based on:

a. documentation requirements in addition to the requirements for creating or maintaining documentation prescribed by state law or rule or federal law or regulation, or

b. a requirement that a provider perform professional duties prescribed by state law or rule or federal law or regulation;

7. a. Recoupment shall only occur following the correction of a claim and shall be limited to amounts paid in excess of amounts payable under the corrected claim.

b. The Authority or the contracted entity may recoup the entire overpaid claim if payment is issued for the corrected claim on the same date.

c. Following a notice of overpayment, a provider shall have at least sixty (60) days to file a corrected claim;

8. Approval of a service, provider, or patient eligibility upon adjudication of a claim shall not be reversed unless the provider obtained the adjudication by fraud or misrepresentation of claim elements;

9. Each provider shall be audited by the Authority or the contracted entity under the same standards and parameters;

10. The Authority or the contracted entity shall disclose to providers all policies, manuals, billing guidelines, and audit criteria and any changes to such policies, manuals, guidelines, and criteria. No recoupment may be based on undisclosed or retroactively applied criteria;

11. A provider shall be allowed at least sixty (60) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit;

12. The period covered by an audit shall not exceed twenty-four (24) months from the date the claim was submitted to the Authority or the contracted entity;

13. a. The preliminary audit report under paragraph 11 of this subsection shall be delivered to a provider within one hundred twenty (120) days after the conclusion of the audit.

b. A final audit report shall be delivered to provider within six (6) months after receipt of the preliminary audit report or receipt of the final appeal as provided for in this subsection, whichever is later; and

14. Notwithstanding any other provision in this section, the Authority or the contracted entity shall not use the accounting practices of statistical sampling, projection, or extrapolation methodologies to calculate alleged overpayments, recoupments, or penalties for audits.

C. 1. The Authority shall establish an appeals process under which a provider may appeal a final audit report to the Authority, and each contracted entity shall adopt the same appeals process. A decision of the Authority or the contracted entity after the appeal shall be final and binding unless a review is requested under paragraph 2 of this subsection.

2. Any decision of the Authority or the contracted entity after the appeal shall be subject to review by an administrative law judge designated by the Administrator of the Oklahoma Health Care Authority upon a timely request for review by the applicant or recipient. The Administrator may only designate an administrative law judge at another state agency, as established in the State Medicaid Plan and approved by the Centers for Medicare and Medicaid Services. The designated administrative law judge shall issue a decision after review.

3. Any applicant or recipient under this title who is aggrieved by a decision of the designated administrative law judge rendered under paragraph 2 of this subsection may petition the district court in which the provider is located within thirty (30) days of the date of the decision for a judicial review of the decision pursuant to the provisions of Sections 318 through 323 of Title 75 of the Oklahoma Statutes. A copy of the petition shall be served by mail upon the general counsel of the Authority.

D. The Authority or the contracted entity shall not take adverse action against a provider for exercising rights conferred by this section including, but not limited to, retaliation through selection for additional audits.

E. A recoupment of any disputed funds shall only occur after final disposition of the audit, including the appeals processes described in subsection C of this section.

F. The total amount of any recoupment on an audit shall be refunded to:

1. The contracted entity if the audited services were provided under a capitated contract. The contracted entity shall report such recoupment to the Authority and shall retain, use, or transfer the funds in accordance with rules promulgated by the Oklahoma Health Care Authority Board; or

2. If the audited services were provided through the fee-for-service portion of the state Medicaid program:

a. the state agency responsible for paying the state share of the Medicaid services provided by the provider, if an agency other than the Authority, or

b. in the absence of the conditions described in subparagraph a of this paragraph, the Authority.

G. This section does not apply to any audit, review, or investigation that involves alleged fraud, willful misrepresentation, or abuse.

H. The Oklahoma Health Care Authority Board shall promulgate rules to implement the provisions of this section.

SECTION 2. This act shall become effective January 1, 2027.

COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES
February 9, 2026 - DO PASS AS AMENDED BY CS