STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

SENATE BILL 1645 By: Gollihare

AS INTRODUCED

An Act relating to the state Medicaid program; defining terms; establishing certain requirements and procedures for audits of long-term care providers; directing the Oklahoma Health Care Authority to establish certain appeals process; providing for review by administrative law judge; authorizing certain judicial review; prohibiting certain adverse action by the Authority; stipulating certain requirements for recoupment of funds; limiting applicability of certain provisions; directing promulgation of rules; 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 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 or an entity on its behalf of a Medicaid claim submitted by a long-term care 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. "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

3. "Long-term care provider" means a:

a. nursing facility,

b. intermediate care facility for individuals with intellectual disabilities (ICF/IID),

c. Medicaid home- and community-based services provider, or

d. program of all-inclusive care for the elderly (PACE) organization,

that is contracted with the Authority to provide services to members of the state Medicaid program.

B. Subject to applicable federal law, when the Oklahoma Health Care Authority conducts an audit of a long-term care provider, the

audit shall be conducted according to the following requirements and procedures:

1. The Authority shall give the long-term care 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 long-term care provider.

b. The Authority shall not cite a long-term care 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 long-term care 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 long-term care 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 long-term care 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 long-term care 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 shall not initiate an

audit of a long-term care 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 long-term care 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 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 long-term care provider shall have at least sixty (60) days to file a corrected claim;

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

9. Each long-term care provider shall be audited by the Authority under the same standards and parameters;

10. The Authority shall disclose to long-term care 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 long-term care 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;

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

b. A final audit report shall be delivered to the long-term care 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 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 long-term care provider may appeal a final audit report to the Authority. A decision of the Authority 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 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 long-term care 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 shall not take adverse action against a long-term care 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 state agency responsible for paying the state share of the Medicaid services provided by the long-term care provider, if an agency other than the Authority; or

2. In the absence of the conditions described in paragraph 1 of this subsection, 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.

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