STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

HOUSE BILL 3358 By: Williams

AS INTRODUCED

An Act relating to Medicaid provider audits; defining terms; providing for review of Medicaid providers or managed care organizations; providing penalties; directing Medicaid providers or managed care organizations to retain records for a certain period of time; requiring the production of records if requested; directing for promulgation of rules; providing for determination of overpayments or credible allegations of fraud; establishing the methodology for audits; providing for notice of right to informal conference and expedited adjudicatory proceeding; mandating that the Oklahoma Health Care Authority allow for corrective action plans; providing qualifications for hearing officer; providing costs for expedited adjudicatory proceeding; allowing Medicaid providers to challenge the preliminary or final determination for overpayment; 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 5029.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Claim" means a request for payment for services;

2. "Clean claim" means a claim for reimbursement that:

a. contains substantially all the required data elements necessary for accurate adjudication of the claim without the need for additional information from the Medicaid provider or subcontractor,

b. is not materially deficient or improper, including lacking substantiating documentation required by Medicaid, and

c. has no particular or unusual circumstances that require special treatment or that prevent payment from being made in due course on behalf of Medicaid;

3. "Credible" means having indicia of reliability after the state has reviewed all allegations, facts, and evidence carefully and acted judicially on a case-by-case basis;

4. "Credible allegation of fraud" means an allegation that has been verified by the state from any source, including fraud hotline complaints, claims data mining, and provider audits;

5. "Department" or "Authority" means the Oklahoma Health Care Authority;

6. "Director" means the director of the Oklahoma Health Care Authority;

7. "Fraud" means any act that constitutes fraud under state or federal law;

8. "Managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements with the Authority to provide health care and related services;

9. "Medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

10. "Medicaid provider" means a person that provides Medicaid-related services to recipients;

11. "Overpayment" means an amount paid to a Medicaid provider or subcontractor in excess of the Medicaid allowable amount, including payment for any claim to which a Medicaid provider or subcontractor is not entitled;

12. "Person" means an individual or other legal entity;

13. "Recipient" means a person who the Authority has determined to be eligible to receive Medicaid-related services; and

14. "Subcontractor" means a person that contracts with a Medicaid provider or a managed care organization to provide Medicaid-related services to recipients.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Consistent with the terms of any contract between the Authority and a Medicaid provider or managed care organization, the director shall have the right to be afforded access to the Medicaid

provider's or managed care organization's records and personnel, as well as its subcontracts and that subcontractor's records and personnel, as may be necessary to ensure that the Medicaid provider or managed care organization is complying with the terms of its contract with the Authority.

B. Upon not less than two days' written notice to a Medicaid provider or managed care organization, the director may carry out an administrative investigation or conduct administrative proceedings to determine whether a Medicaid provider or managed care organization has:

1. Materially breached its obligation to furnish Medicaid-related services to recipients, or any other duty specified in its contract with the Authority;

2. Intentionally or with reckless disregard advertised or marketed, or attempted to advertise or market, its services to recipients in a manner as to misrepresent its services or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing; or

3. Fraudulently procured or attempted to procure any benefit from Medicaid.

C. Subject to the provisions of subsection D of this section, after affording a Medicaid provider or managed care organization written notice of hearing not less than ten (10) days before the hearing date and an opportunity to be heard, and upon making

appropriate administrative findings, the director may take any or any combination of the following actions against the Medicaid provider or managed care organization:

1. Impose an administrative penalty of not more than Five Thousand Dollars ($5,000.00) for engaging in any practice described in subsection B of this section, provided that each separate occurrence of such practice shall constitute a separate offense;

2. Issue an administrative order requiring the Medicaid provider or managed care organization to:

a. cease or modify any specified conduct or practices engaged in by its employees, subcontractors or agents,

b. fulfill its contractual obligations in the manner specified in the order,

c. provide any service that has been denied,

d. take steps to provide or arrange for any service that it has agreed or is otherwise obligated to make available, or

e. enter into and abide by the terms of a binding or nonbinding arbitration proceeding, if agreed to by any opposing party, including the director; or

3. Suspend or revoke the contract between the Medicaid provider or managed care organization and the department pursuant to the terms of that contract.

D. If a contract between the Authority and a Medicaid provider or managed care organization explicitly specifies a dispute resolution mechanism for use in resolving disputes over performance of that contract, the dispute resolution mechanism specified in the contract shall be used to resolve such disputes in lieu of the mechanism set forth in subsection C of this section.

E. If a Medicaid provider's or managed care organization's contract so specifies, the Medicaid provider or managed care organization shall have the right to seek de novo review in district court of any decision by the director regarding a contractual dispute.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.12 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Medicaid providers, managed care organizations, and their subcontractors shall retain, for a period of at least six (6) years from the date of creation, all medical and business records that are necessary to verify the:

1. Treatment or care of any recipient for which the Medicaid provider, managed care organization, or their subcontractor received payment from the Authority to provide that benefit or service;

2. Services or goods provided to any recipient for which the Medicaid provider, managed care organization, or subcontractor

received payment from the Authority to provide that benefit or service;

3. Amounts paid by Medicaid or the Medicaid provider or managed care organization on behalf of any recipient; and

4. Records required by Medicaid under any contract between the Authority and the Medicaid provider or managed care organization.

B. Upon written request by the Authority to a Medicaid provider, managed care organization, or any subcontractor for copies or inspection of records pursuant to this act, the Medicaid provider, managed care organization, or subcontractor shall provide the copies or permit the inspection, as applicable within two (2) business days after the date of the request unless the records are held by the subcontractor, agent or satellite office, in which case the records shall be made available within ten (10) business days after the date of the request.

C. Failure to provide copies or to permit inspection of records requested pursuant to this section shall constitute a violation of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.13 of Title 63, unless there is created a duplication in numbering, reads as follows:

The director shall adopt and promulgate rules appropriate to administer, carry out, and enforce the provisions of this act.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.14 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Authority may audit a Medicaid provider or subcontractor for overpayment, using sampling for the time period audited. If the Authority contracts for the audit, the Authority shall contract only with an independent auditor approved by the state auditor. Each audited claim shall be reviewed by a person who is licensed, certified, registered, or otherwise credentialed in Oklahoma as to the matters such person reviews, including coding or specific clinical practice.

B. The Authority shall not extrapolate audit findings unless a Medicaid provider's or subcontractor's error rate exceeds ten percent (10%) based upon appropriate samplings and a representative sample of claims computed by valid statistical software approved by the United States Department of Health and Human Services.

C. Prior to reaching either a final determination or overpayment or a credible allegation of fraud, the Authority shall serve the Medicaid provider or subcontractor with a written preliminary finding of overpayment.

D. The preliminary finding of overpayment shall:

1. State with specificity the factual and legal basis for each claim forming the basis of an alleged overpayment;

2. Include a copy of the final audit report if the alleged overpayment is based on an audit; and

3. Notify the Medicaid provider or subcontractor that is the subject of a preliminary finding of overpayment of its right to request, within thirty (30) calendar days of service of the preliminary finding of overpayment, an informal conference with a representative of the Authority who is knowledgeable about the Authority's preliminary finding of overpayment and with a member of the audit team, if an audit formed the basis of any alleged overpayment, to informally address, resolve, or dispute the Authority's preliminary finding of overpayment.

E. Prior to making either a final determination of overpayment or a determination of credible allegation of fraud, the Authority shall impose corrective action upon the Medicaid provider or subcontractor to address systemic conditions contributing to errors in the submission of claims for payment to which a Medicaid provider or subcontractor is not entitled.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.15 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A Medicaid provider or subcontractor seeking an informal conference pursuant to this section shall serve the Authority with a written request for such conference no later than thirty (30) calendar days following the service of a preliminary determination

of overpayment by the Authority on the Medicaid provider or subcontractor. Upon receipt of a request for an informal conference, the Authority shall set a date for the conference to occur no later than fourteen (14) business days following receipt of the request.

B. Within seven (7) business days following the informal conference, a Medicaid provider or subcontractor may submit a proposed corrective action plan to the Authority to correct clerical, typographical, scrivener's, and computer errors or to provide requested credentialing, licensure, or training records identified in audit findings. The Authority shall not unreasonably withhold approval of the proposed corrective action plan. A Medicaid provider or subcontractor shall have no less than thirty (30) business days from the date of approval of its corrective action plan to provide additional information or documentation to the Authority to attempt to address or resolve a disputed preliminary finding of overpayment.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.16 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A Medicaid provider or subcontractor seeking an expedited adjudicatory proceeding pursuant to this act shall serve the Authority and the administrative hearings office with a written request for such proceeding no later than thirty (30) calendar days

following the service of a final determination of overpayment by the Authority on the Medicaid provider or subcontractor.

B. The chief hearing officer of the administrative hearings office shall appoint or contract with a hearing officer qualified to hear these types of hearings no later than thirty (30) calendar days after service upon the administrative hearings office of a request for an expedited adjudicatory proceeding pursuant to this act by a Medicaid provider or a subcontractor.

C. The expedited adjudicatory proceeding requested by a Medicaid provider or subcontractor in accordance with this act shall commence no later than thirty (30) days following the appointment of the hearing officer or as stipulated by the parties or as otherwise ordered by the hearing officer upon a showing of good cause. The evidentiary hearing of an expedited adjudicatory proceeding pursuant to this section shall not exceed ten (10) business days in length.

D. After affording the parties the opportunity to submit proposed findings and conclusions of law, and based solely upon the record in accordance with this act and the Administrative Procedures Act, the hearing officer shall make findings of fact and conclusions of law on all material issues of fact, law or discretion, stating the basis for each. In addition, the hearing officer shall determine the amount of overpayment with respect to each disputed claim submitted for payment, if any. The findings of fact and conclusions of law of the hearing officer shall be made and served

upon all parties of record within thirty (30) calendar days following the hearing officer's receipt of the record.

E. The hearing officer's findings of fact and conclusions of law shall be binging on the Authority and constitute a final agency decision.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.17 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The hearing officer presiding over the expedited adjudicatory proceeding held pursuant to this act shall:

1. Be licensed and in good standing to practice law in Oklahoma or another state;

2. Have at least three (3) years cumulative experience in one or more of the following areas:

a. the health insurance industry,

b. the Medicaid program,

c. health care regulatory compliance,

d. medical claims administration, or

e. health law;

3. Not currently be employed by or represent, or belong to a law firm that currently represents, the Authority or a Medicaid provider or managed care organization or third-party administrator currently doing business with the Authority; and

4. Not be related within the third degree of consanguinity to a person currently employed by the Authority, currently doing business with the Authority, or currently employed by an organization doing business with the Authority.

B. The hearing officer shall not be:

1. A lobbyist registered with the Ethics Commission who currently represents, or has in the prior calendar year represented, a client in matters before the Authority; or

2. Affiliated with, or the spouse of, a lobbyist registered with the Ethics Commission who currently represents, or has in the prior calendar year represented, a client in matters before the Authority.

C. The chief hearing officer of the administrative hearings office shall select the hearing officer to preside over an expedited adjudicatory proceeding held pursuant to this act.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.18 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each party shall be responsible for its own costs related to the expedited adjudicatory proceeding, including costs associated with preparation for the hearing, discovery, depositions, subpoenas, service of process, witness expenses, travel expenses, investigation expenses and attorney fees.

B. The hearing officer shall allow telephonic testimony of a witness, if requested by a party.

C. The Authority shall reimburse the administrative hearings office for the costs of a contract hearing officer.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.19 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A Medicaid provider or subcontractor may challenge:

1. The Authority's preliminary or final determination of overpayment as:

a. exceeding statutory authority,

b. arbitrary or capricious,

c. a failure to follow Authority procedure, or

d. not supported by substantial evidence;

2. The credentials of persons who participated in the audit or claims review; or

3. The methodology or accuracy of the Authority's audit.

B. A Medicaid provider or subcontractor may conduct its own audit or sampling to challenge a preliminary or final determination of overpayment.

SECTION 11. This act shall become effective November 1, 2026.

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