STATE OF NEW YORK

9219

IN SENATE

February 17, 2026

Introduced by Sen. STEC -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the social services law, in relation to Medicaid accountability

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Legislative findings and intent. 1. The legislature finds that audits and reviews conducted by the state comptroller, the office of the Medicaid inspector general, and other oversight entities have repeatedly identified improper Medicaid payments arising from enrollment inaccuracies, delayed eligibility verification, claims processing weaknesses, and inconsistent follow-through after audit findings. Such improper payments include payments made on behalf of individuals who are deceased, duplicatively enrolled, not a resident of New York State, no longer eligible, or otherwise inaccurately reflected in program records.

2. The legislature further finds that improving payment accuracy requires clear statutory expectations, predictable administrative processes, and timely corrective action, while maintaining continuity of care for eligible beneficiaries and operational clarity for managed care plans and providers.

3. The purpose of this act is to strengthen Medicaid payment accountability by requiring routine eligibility verification cross-checks, mandating audits in defined high-risk areas, establishing structured payment safeguards with notice and response periods, and authorizing limited verification tools to confirm service delivery, while preserving existing eligibility standards, benefits, and due process protections.

§ 2. The public health law is amended by adding three new sections 37, 38 and 39 to read as follows:

§ 37. Routine eligibility and enrollment verification. 1. The department, in coordination with the office and the office of temporary and disability assistance, shall conduct cross-checks of Medicaid enrollment data no less than once annually, for the purpose of verifying ongoing eligibility and enrollment accuracy.

2. Such cross-checks shall include, but not be limited to:

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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(a) state and federal death records;

(b) duplicative or multiple active enrollments across eligibility categories or geographic jurisdictions;

(c) residency indicators relevant to Medicaid eligibility and managed care program enrollment pursuant to section three hundred sixty-four-j of the social services law;

(d) lawfully available federal eligibility verification data, including immigration-related eligibility information, to the extent permitted under federal law and solely for the purpose of verifying Medicaid eligibility or enrollment category; and

(e) such other data sources as the commissioner determines necessary to confirm eligibility accuracy.

3. Nothing in this section shall be construed to:

(a) alter Medicaid eligibility standards;

(b) expand the use of immigration-related information beyond eligibility verification purposes permitted under federal law; or

(c) permit the denial, suspension or termination of coverage without appropriate notice, opportunity to respond, and due process as otherwise required by law.

4. Implementation of the provisions of this section shall occur pursuant to a phased schedule established by the department to ensure operational readiness.

§ 38. Medicaid audit requirements. 1. The office, in consultation with the department, shall conduct recurring annual audits of Medicaid program areas identified as presenting an elevated risk of improper payments.

2. At a minimum, such audits shall include reviews of:

(a) managed care program premium payments made pursuant to section three hundred sixty-four-j of the social services law and enrollment accuracy;

(b) claims processing systems, edits, and payment controls;

(c) hospital billing classification, including inpatient and outpatient site-of-service accuracy; and

(d) service verification and program integrity controls, including electronic visit verification where applicable.

3. Audits conducted pursuant to this section shall require:

(a) written corrective action plans with defined implementation timelines promulgated by the department;

(b) recovery of improper payments where identified, consistent with state and federal law; and

(c) escalation measures, including systems changes or payment safeguards, when the same material deficiencies are identified in successive audits.

4. Implementation of the provisions of this section shall occur pursuant to a phased schedule established by the department to ensure operational readiness.

§ 39. Biometric verification pilot program. 1. The department shall establish a limited, time-bound biometric verification pilot program for the purpose of confirming service delivery or beneficiary identity in Medicaid programs or managed care program settings identified as presenting a heightened risk of improper payments.

2. Such pilot program shall be subject to the following limitations and safeguards:

(a) use shall be limited to point-of-service or point-of-delivery verification;

(b) facial recognition technology shall be expressly prohibited;

(c) biometric data, other than facial recognition data, shall be stored solely as encrypted, non-reversible templates and not as images;

(d) biometric data, other than facial recognition data, shall be used exclusively for Medicaid program integrity purposes; and

(e) data retention, access, and destruction standards shall be established by regulation by the department.

3. Participation in verification procedures required under this section shall be a condition of initial and continued eligibility in Medicaid programs and managed care programs pursuant to section three hundred sixty-four-j of the social services law. The department shall provide reasonable accommodations and non-biometric alternatives for individuals with disabilities or documented hardship. No individual shall be terminated or denied medically necessary services without prior written notice and opportunity for a fair hearing in accordance with existing Medicaid due process requirements.

4. The department shall evaluate the effectiveness, administrative burden, privacy impacts, and fiscal outcomes of the pilot program and report such findings to the legislature.

§ 3. Section 35 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. The inspector and the department shall submit reports to the legislature, at least annually, summarizing audit findings pursuant to section thirty-eight of this article, corrective actions taken, amounts recovered or avoided by such actions, managed care program payment safeguards applied pursuant to subdivision forty-one of section three hundred sixty-four-j of the social services law, and the results of the biometric verification pilot implemented pursuant to section thirty-nine of this article.

§ 4. Section 364-j of the social services law is amended by adding a new subdivision 41 to read as follows:

41. (a) The managed care program shall provide payment safeguards consistent with the following provisions:

(i) when routine verification or audit activity pursuant to sections thirty-seven and thirty-eight of the public health law identify credible and documented indicators that an individual may no longer be eligible for Medicaid or appropriately enrolled in a managed care program, the department of health shall notify the affected managed care program and initiate a verification resolution process;

(ii) during such verification resolution process, and consistent with federal managed care requirements, including but not limited to actuarial soundness standards, the department of health shall direct managed care program premium payments associated with such individual to be placed into escrow pending a final determination of eligibility;

(iii) escrowed payments shall be released to the managed care program if eligibility or enrollment accuracy is confirmed or retained for recoupment if such managed care program premium payments are determined to be improper;

(iv) such managed care program premium payments determined to be improper shall be subject to recoupment in accordance with applicable state and federal law; and

(v) the department of health shall establish by regulation reasonable response timeframes for managed care programs to submit documentation or corrective actions prior to further escalation.

(b) Implementation of the provisions of this subdivision shall occur pursuant to a phased schedule established by the department of health to ensure operational readiness.

§ 5. This act shall take effect immediately; provided, however, that the amendments to section 364-j of the social services law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith.