

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:

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

10 2. The legislature further finds that improving payment accuracy
11 requires clear statutory expectations, predictable administrative proc-
12 esses, and timely corrective action, while maintaining continuity of
13 care for eligible beneficiaries and operational clarity for managed care
14 plans and providers.

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

21 § 2. The public health law is amended by adding three new sections 37,
22 38 and 39 to read as follows:

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

28 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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1 (a) state and federal death records;
2 (b) duplicative or multiple active enrollments across eligibility
3 categories or geographic jurisdictions;

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

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

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

13 3. Nothing in this section shall be construed to:

14 (a) alter Medicaid eligibility standards;

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

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

20 4. Implementation of the provisions of this section shall occur pursu-
21 ant to a phased schedule established by the department to ensure opera-
22 tional readiness.

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

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

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

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

32 (c) hospital billing classification, including inpatient and outpa-
33 tient site-of-service accuracy; and

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

36 3. Audits conducted pursuant to this section shall require:

37 (a) written corrective action plans with defined implementation time-
38 lines promulgated by the department;

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

41 (c) escalation measures, including systems changes or payment safe-
42 guards, when the same material deficiencies are identified in successive
43 audits.

44 4. Implementation of the provisions of this section shall occur pursu-
45 ant to a phased schedule established by the department to ensure opera-
46 tional readiness.

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

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

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

56 (b) facial recognition technology shall be expressly prohibited;

1 (c) biometric data, other than facial recognition data, shall be
2 stored solely as encrypted, non-reversible templates and not as images;
3 (d) biometric data, other than facial recognition data, shall be used
4 exclusively for Medicaid program integrity purposes; and
5 (e) data retention, access, and destruction standards shall be estab-
6 lished by regulation by the department.

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

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

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

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

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

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

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

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

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

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

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

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

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