Testimony of The Downstate Coalition for Quality Home Care
Before the Joint Legislative Public Hearing on the SFY 2026-2027 Executive Budget Proposal:
Topic Health & Medicaid

Help Ensure Adequate Rates for Licensed Home Care Services Agencies
February 10, 2026

Thank you, Senator Krueger and Assemblymember Pretlow, and to all the committee chairs and members, for the opportunity to testify on Governor Hochul's proposed Health and Medicaid budget for State Fiscal Year 2026-2027.

The Downstate Coalition for Quality Home Care (Coalition) represents the State's largest downstate licensed home care services agencies (LHCSAs). Together, we provide Medicaid-eligible older adults, individuals with disabilities, and people who are chronically ill, with long-term services and supports in their home and community. Our home care agencies deliver care in the five boroughs and surrounding counties to tens of thousands of individuals, and most of our members employ tens of thousands unionized home care workers, primarily organized by 1199SEIU.

Licensed home care services agencies are the backbone and original providers of community based long term care. State licensure, regulation, and oversight ensure the LHCSAs are accountable for quality care. For several years, we have offered testimony ringing the bell on the challenges faced by LHCSAs and out of concern for the future of the State's home health care services and the population they serve. We now tell you that community-based home care is at a critical juncture.

The foundational issue that LHCSAs face is that the rates they receive from managed care plans do not cover the costs of meeting increasing minimum wage and other mandates. For example, all our members have reported:

- Managed care plans providing a rate increase less than that of the minimum wage increase
- Managed care plans *reducing* rates when minimum wage is increasing
- Managed care plans providing rates that are the same or lower as several years ago despite minimum wage increases during that time.

This math does not work. **To ensure stability of the sector going forward, we urge the Legislature to include the following in any final budget:**

<u>Fix</u> the Rate Process, Part 1

Coalition members recognize fiscal realities and hear the Administration when they say that there are sufficient dollars in the system to cover minimum wage increases and their attendant costs. To this end, the Coalition proposed a policy to address the *process* issues related to LHCSA rates, specifically asking that the State apply to the Centers for Medicaid and Medicare Services (CMS) for a state directed payment establishing a minimum fee schedule for LHCSAs that participate in Medicaid Advantage Plus plans and PACE programs. This would allow the State to tell plans that they must pay no less than, for example, the fee for service rate for LHCSAs; at the same time, it would encourage enrollment in fully integrated Medicaid managed care products.

Pursuant to a Dear Administrator Letter dated December 31, 2025, the State did direct plans to pay no less than the FFS rates – but only for PPL and the consumer directed personal assistance program.

We appreciate the Administration's ability to recognize issues related to managed care rates and dollar flow, and we simply ask that that the same approach be applied to LHCSAs. This could be done administratively, but since they have failed to act, we ask the Legislature consider the attached language, which would require the Department of Health to apply to the Centers for Medicaid and Medicare Services (CMS) to approve a state-directed payment setting a minimum fee schedule for LHCSAs based on fee-for-service rates for MAP and PACE programs. This would advance the Hochul Administration's goal of advancing fully capitated integrated long term care managed care models, and this language could be included in the HMH Article VII or introduced as a freestanding bill.

Additionally, to the extent there is interest in advancing legislation that would eliminate MLTCs and generate savings from doing so (e.g., A2018/S2332), we make the following observations and recommendations:

- There does not appear to be a clearly articulated vision for the future of community based long term care for New Yorkers, and the foundation of the system (especially LHCSAs) is falling apart. Any savings achieved from elimination of administrative inefficiencies in managed long term care should be reinvested into the community based long care system.
- Establishing a "managed fee for service" option is at odds with past and present federal administrations' philosophies is unlikely to get approved and even less likely to drive savings for the State. To the extent that partially capitated plans are no longer offered in New York, we recommend that the State passively enroll dual eligibles into fully integrated products.
- To assist in the migration of beneficiaries to fully integrated products, and to recognize the funds flow issues experienced by LHCSAs currently in their negotiation with CMS, we further recommend including the attached language directing DOH to apply to CMS for a state directed payment setting a minimum fee schedule for LHCSAs.
- Definitions and processes regarding the system that arises after an elimination of MLTCs should also be clearly articulated rather than left to regulation.

Include Home Care In New Investments

In her budget, Governor Hochul recognized the challenges faced by the State's health care delivery system, but only for hospitals and nursing homes. We understand the challenges faced by those entities, but the healthcare ecosystem is symbiotic, with the various pieces reliant on each other. Given the robust investment in hospitals and nursing homes, and the additional unanticipated revenue from nine additional months of the MCO tax, investment in home care is warranted and doable. Failure to make this investment and allowing community based long term care options to fail only puts greater pressure on hospitals and nursing homes seeking to discharge people back into the community. **Ask: Allocate $100 million for investment in home care.**

BACKGROUND: WHAT ARE LHCSAs AND WHY ARE THEY STRUGGLING?

LHCSAs, that are licensed and regulated by the Department of Health, can offer home care services including all levels of nursing care, various therapies, home health aides and personal care aides to clients who pay privately, have private insurance coverage or are covered through a variety of government payers. Many LHCSAs also deliver services under contract with local departments of social services or other service-authorizing agents. Services through the Medicaid Personal Care and Private Duty Nursing programs, particularly, are delivered in this way. LHCSAs that deliver Medicaid services follow both DOH licensure regulations and reporting and Medicaid regulations and reporting. Licensed agencies also subcontract with other home care providers, housing programs, and other payers to deliver services to care recipients throughout New York State. LHCSAs may offer a full range of services

from skilled to paraprofessional or may choose to focus on the delivery of one service or population, such as high-tech pediatrics or aides for seniors with cognitive impairments.

In the past several years, the Legislature has rightfully recognized that home care work should be recognized as more than just a minimum wage job, and created a special minimum wage for home care workers. Over the years, however, payers consistently and routinely have failed to pass through rates to cover provider costs associated with these wage increases. The Legislature has supported budgets that include funding for these wage increases and DOH has included some aspect of this funding in payments to managed care plans. These funds are not adequately passed through to providers to support mandatory wage increases. Similarly, previously enacted Across the Board (ATB) Medicaid rate increases for providers were never passed through to providers as supplemental funding to support ongoing cost challenges.

Employer Costs of Wage Increases Are Not Being Met in the Rates. Employers of home care workers are mandated to meet wage, labor, benefit and tax requirements, in addition to various mandates of the Department of Health. With this most recent increase, regardless of geography or union status, every licensed home care services agency in the State will see increased costs for:

- Payroll taxes
- Workers' comp taxes
- Unemployment benefits
- FLSA - Overtime, travel and live-in services
- In-service training
- NYS Department of Labor mandates (e.g., split shifts and spread of hours)
- COVID sick pay
- Patient-related care costs

Additionally, unionized LHCSAs across the State (including but not limited to Nassau, Suffolk and Westchester, and NYC) have costs related to Collective Bargaining Agreements obligations (health, pension, training and paid time off costs). This reimbursement insufficiency has resulted in LHCSAs eliminating health care coverage, reducing holiday pay, and reducing paid time off.

Employer Costs are Unaddressed and Unfunded. This is true, not just in the context of the recent wage increases, but for provider rates overall. Simply put, the rates are not keeping pace with costs; they have not for years; and each new mandate creates a heightened burden that threatens this important safety net.

In addition to wage increase costs, providers have growing uncompensated costs related to the provision of services that exist separate and apart from the costs of putting the aide in the home. Home care providers were particularly hard hit by the pandemic. Without the scale or early access (and sometimes no access) to federal emergency funds, the licensed home care services providers were forced to deal with dramatic unbudgeted and unreimbursed costs for PPE, COVID sick pay and overtime. And many of these costs (PPE, etc.) have continued on in the "new normal".

During this time, the State provided no relief. The State has cut MLTCP/MCO rates, and those cuts were passed down to the providers. Year after year, LHCSAs have had cost increases across the board with no relief provided….and when there was relief in the form of ongoing ATB rate increases, only the rates paid to providers through State fee for service rates received the 1% rate increase.

Furthermore, the Executive's proposal seeks to limit administrative and general (A&G) costs for fee for service (FFS) personal care rates to 15% and that it is a first step toward standardizing personal care A&G. At this point, we have received no information that explains the methodology behind this proposal (a cut of $7.5M state share) and what is included as an A&G expenses. Generally, personal care rates have considered any expense beyond aide wages and benefits to be administrative – including direct programmatic costs for nurses, training, and patient coordination. Establishing caps on such expenses is short-sighted and will further challenge providers' abilities to comply with regulatory and policy mandates and accommodate unexpected expenses, meet increasing cost burdens, and invest in innovations. Until a thoughtful review of rates and expenses, we urge the Legislature to reject the 15% cap as proposed by the Executive.

In the past, many home care providers had invested considerable resources to participate in value-based arrangements to drive quality and allow for alternative payment methodologies. However, there have been actions to eliminate quality incentive programs and value-based payment arrangements that could have increased positive outcomes in the home care/long term care sector.

Healthcare Workforce Retraining Initiative (HWRI), Workforce Investment Organization (WIO), and other funding streams to support enhanced training have been eliminated or are winding down. The recently announced 1115 Waiver's workforce initiatives are not available to home care workers—in fact, there were no commitments to support services for aging New Yorkers, despite growing needs.

We need stability in community-based long term care, not further disruption.[1] This can partially be achieved by including the attached language in the final budget to direct DOH to seek a state directed payment to set a minimum fee schedule for LHCSAs in the context of integrated managed products.

Home Care Investments Have Stalled.

While the Governor and the Legislature have rightfully recognized and accommodated for the wages of home care workers, operational funding needs for LHCSAs remain unaddressed. Accordingly, the Coalition members have ongoing struggles with stabilizing the foundation for the continued provision of home care services. Agencies grapple to meet the needs of a diminishing workforce and the Medicaid clients they continue to serve, all with decreasing funding which was further eroded by the pandemic.

While the Governor has yet to identify a long-term care strategy for the State, what we do know is that LHCSAs have been struggling with increasingly limited resources and growing need. Accordingly, we ask the ***Legislature to allocate $100M of the Governor's new $750M healthcare investment to stabilize rates for LHCSAs.***

The allocation would be used to ensure that home care agencies receive adequate funding to pay mandated wages, stop losses, stabilize and invest in the future of the system.

Thank you for your consideration.

[1] We note the Governor last year also made changes to yet another community based long term care program, the Nursing Home Transition and Diversion (NHTD) Waiver program, which will further the crisis of community based long term care in the State.

ATTACHMENT A

AN ACT to amend the public health law, in relation to regional minimum hourly base reimbursement rates for home care aides

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

Section 1. Section 3614-f of the public health law is amended by adding eight new subdivisions 5, 6, 7, 8, 9, 10, 11 and 12 to read as follows:

5. (a) No medicaid managed care organization shall reimburse providers employing workers subject to the minimum wage provisions established in subdivision two of this section in an amount that is less than the most current average fee for service county rates for level two personal care service for each region as posted by the department for personal care agencies or other providers delivering like services through other Medicaid programs.
(b) Alternatively, the commissioner may require Medicaid managed care organizations to pay a regional minimum hourly base reimbursement rate, which the commissioner will develop based on the total direct care related costs for home care aides and other direct care related staff necessary to comply with federal and state statutory and regulatory requirements for such providers and informed by provider cost reports filed with the department, provided that such resulting rate is not less than the fee for service rate in subparagraph (a) of this subsection. If the commissioner chooses to exercise this option, the minimum rate identified in subdivision (a) of this subsection shall apply until the regional minimum hourly base reimbursement rate is developed and implemented.

6. For mainstream managed care and fully capitated Medicaid managed care products for those dually eligible for both Medicaid and Medicare, the commissioner shall submit any and all necessary applications for approvals and/or waivers to the federal centers for Medicare and Medicaid services to secure approval, if necessary, under subsection five of this section.
(a) If approved by the federal centers for Medicare and Medicaid services, directed payments shall be made to such providers of Medicaid services through contracts with managed care organizations where applicable, provided that the commissioner ensures that such directed payments are in accordance with the terms of this section.
(b) If the state directed payment is not approved, the provisions of subdivision seven of this section shall apply.

7. For partially capitated managed long term care plans, or where state directed payments pursuant to subdivision six of this section have not been approved, the department shall require plans to justify contracts offering deviations from the reimbursement rate set in subsection five of this section in a report to the department. This report shall be sent to the department, with a copy to the provider prior to the finalizing of any contract, unless otherwise permitted by this section, within five working days of the contract being offered to a provider with rate deviations. Any report

shall include a rationale for paying below the reimbursement rate set in subsection five of this section, and the impacted provider shall have the opportunity to respond to the report within thirty days of filing with the department. The department shall compile such reports and publish and post a summary of them semi-annually.

8. The commissioner shall take action to ensure rate ranges for Medicaid managed care organizations are actuarially sound in order to comply with this section.

9. Nothing in this section shall preclude providers employing home health aides covered under this section or payers from paying or contracting for services at rates higher than those established under subsection five if the parties mutually agree to such terms. Notwithstanding subdivision seven of this section, plans and providers can also mutually agree to enter into value-based contracts at a rate less than that established in subsection five of this section.

10. The commissioner shall amend the model managed care contracts to reflect the requirements of this section.

§ 2. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this act, or any other application of any provision of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 3. This act shall take effect immediately.