July 8, 2026

HCPInsider

One Focus. One Industry. **One Voice.**

IN THIS ISSUE:

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POLICY PULSE

PPL Settles CDPAP Class Action Wage Lawsuit

Public Partnerships LLC (PPL), the statewide fiscal intermediary for New York's Consumer Directed Personal Assistance Program (CDPAP), agreed to a proposed $162 million settlement to resolve *Calderon v. Public Partnerships LLC*, a class action lawsuit filed on behalf of 200,000 personal assistants (PA).

The lawsuit was filed after PAs suffered months of payroll and benefit issues as New York transitioned to a single statewide fiscal intermediary in 2025. When PPL took over the program, caregivers and consumers reported late or missed paychecks, incorrect wages, unpaid accrued paid time off (PTO), failure to properly provide worker wage parity benefits, and improper deductions taken from workers' pay to fund PPL's Minimum Essential Coverage (MEC) health plan.

The MEC health insurance plan primarily covered preventive services and did not provide comprehensive medical coverage for physician visits or hospital care. The plan was criticized by workers who were required to contribute to the plan through payroll deductions, even if they had health insurance from another source.

Although PPL denies any wrongdoing or liability, the company agreed to settle to avoid the costs and uncertainty of prolonged litigation. The proposal still needs to be approved by the court, but it will provide cash payments to eligible personal care assistants, reconcile unpaid PTO balances, distribute wage parity funds previously allocated to the MEC health plan, and return at least $25 million associated with the MEC health plan. The amount each personal assistant receives will vary but payments should be distributed in early 2027.

The proposed settlement is one of the largest wage-related settlements in New York and highlights the scale of the payroll issues that accompanied the transition to a single statewide fiscal intermediary.

The settlement resolves claims related to worker compensation during the transition but does not address the broader disputes over the state's procurement process or the policy decision to consolidate CDPAP under a single fiscal intermediary.

HCP Priority Bills and Their Future

In the 2025/2026 legislative session, HCP prioritized the following legislation when lobbying lawmakers in the State Senate and Assembly. Building on our success, HCP plans to start the next legislative session even stronger. If you have any questions or concerns with the legislation previously prioritized or wish to highlight additional legislation for consideration email publicpolicy@nyshcp.org.

HCP Priority Bills, detailed

BILL NUMBERS: Assembly Senate	2025 / 2026 SESSION STATUS	SUMMARY	PURPOSE
N/A S707-A (May)	A-print not introduced Passed	Requires Managed Long Term Care (MLTC) plans to report annually on the utilization of each plan's services, associated expenditures and usage rates by members, the types of complaints and issues received by each plan, and metrics about timely access to authorized services.	Makes MLTC reporting publicly available to improve accountability and consumer choice by allowing them to compare plans.
A1112 (Paulin) S3599 (Rivera)	Health Committee Health Committee	Requires the Department of Health (DOH) to create regional minimum hourly base reimbursement rates for home care aides, aligning with 2022 minimum wage increases.	Establishes an objective standard, which accounts for DOH determined elements, against which to measure negotiated rates.
A11569(De Los Santos) S9573(Rivera)	Passed Passed	Authorizes the commissioner of health to establish nursing facility transition and diversion Medicaid waiting lists per designated waiver region, once the federally approved capacity for the waiver is reached.	Makes NHTD waivers more equitable, effective, and seamless for those who apply.
A1198 (Paulin) S358 (Rivera)	Health Committee Health Committee	Repeals the requirement of needing support with at least 3 activities of daily living (ADL) for eligibility to receive Medicaid home care services.	Restores previous Medicaid eligibility criteria for personal care services.
A2735 (Stirpe) S1189 (Rivera)	Health Committee Health Committee	Repeals the transition to a single Fiscal Intermediary (FI). Increases the metrics reported by all FI's and requiring FI licensing.	Addresses concerns related to program integrity by creating FI licensing structure / procedure rather than a single FI.

HCP Priority Bills, detailed

BILL NUMBERS: Assembly Senate	2025 / 2026 SESSION STATUS	SUMMARY	PURPOSE
A5115 (Stern) S674 (Martinez)	Passed Passed	Replace the requirement for an independently audited financial statement with an independent accountant's report on applying agreed upon procedures for annual compliance statement of wage parity.	Codifies existing DOH guidance on home care worker wage parity compliance to decrease compliance costs for providers.
A8137 (Paulin) S7874 (Rivera)	Health Committee Finance Committee	Repeals requirement for LHCSAs to apply for a special DOH contract/approval to serve Medicaid patients.	Eliminates DOH's ability to arbitrarily limit the number of LHCSAs that may participate in Medicaid.
A9607 (Paulin) S9562 (Cleare)	Health Committee Health Committee	Provides LHCSAs an independent dispute resolution process for disputing billing or contracts, retaliation protections, timely review and approval.	Increases capabilities of LHCSAs to negotiate contracts and rates with MLTCs and Managed Care Organizations (MCOs).
A9630 (Paulin) S9563 (Cleare)	Health Committee Health Committee	Requires payment for work by Personal Care Aides (PCA) or Home Health Aides (HHA) with temporary protected status (TPS) or other visa status when a LHCSA has made good faith efforts to establish the employment eligibility consistent with federal regulation and statutes.	Protects providers from payment recoupment if an employee's federal immigration status or eligibility changes while providing or having provided authorized home care services.
A10168 (Seawright) S9091 (Cleare)	Ways & Means Comm. Passed	Establishes a public-facing state master plan on aging dashboard.	Increases transparency on the progress and implementation of the state master plan on aging.

REGULATORY RUNDOWN

OSC Identifies $12.1 Million in Improper Medicaid Payments

An audit by the New York State Office of the State Comptroller (OSC) identified more than $12.1 million in improper Medicaid payments, and identified areas were the Department of Health (DOH/the Department) could strengthen oversight of the Medicaid program.

The audit examined whether eMedNY, the state's electronic Medicaid claims processing and payment system, reasonably ensured Medicaid claims were submitted by approved providers, processed in accordance with requirements, and resulted in correct payments to providers. eMedNY is the platform providers use to submit claims and receive reimbursement for covered services. Between April 1 and September 20, 2025 (certain claims reviewed fell outside that period), eMedNY processed almost 331 million claims totaling nearly $55 billion in Medicaid payments.

The audit determined that eMedNY generally worked as intended but also identified weaknesses that led to $12.1 million in improper payments. Additional oversight and monetary recovery were recommended.

The largest issue uncovered by the audit was the delay in identifying and disenrolling Medicaid members with comprehensive third-party health insurance. These individuals should have enrolled in fee for service and their inclusion in managed care resulted in improper premium payments totaling approximately $6.3 million.

Auditors also found that providers did not always verify whether a Medicaid member had other insurance coverage prior to billing Medicaid. This resulted in $2.2 million that should have been billed to another insurer first, as Medicaid is a payer of last resort.

The audit also identified errors in reporting and duplicate claims resulting in $186,409 in improper Supplemental Maternity and Low Birth Weight Newborn Capitation Payments and overpayments to inpatient and clinics.

By the end of the audit, DOH recovered nearly $3.4 million of the improper payments identified by the OSC audit.

The audit also raised concerns about provider oversight. Auditors identified 14 active Medicaid providers who were charged with or found guilty of health care related crimes that barred them from participating in the Medicaid program. During the audit period, DOH removed 12 providers from the program. The remaining two providers were referred by the Office of the Medicaid Inspector General (OMIG) to the NYS Education Department's Office of Professions and DOH's Office of Professional Medical Conduct for further action.

In addition to recovering improper payments, OSC recommended that DOH impose more timely sanctions against providers who violate Medicaid or other health insurance program provisions. The Department agreed with the audit's recommendations and indicated certain corrective actions were already underway. DOH will officially respond to the audit later this year outlining the steps it has taken to implement the OSC recommendations.

ADA Website Accessibility: Reduce Lawsuit Risks

Accessibility lawsuits are on the rise, with over 5,000 website accessibility lawsuits filed in 2025. Maintaining accessibility for your businesses' website is important, considering the populations LHCSAs serve advocates can target the industry to fight for increased accessibility.

Under Title III of the Americans with Disabilities Act (ADA), websites open to the public must be “reasonably accessible”. There are no specific technical regulations regarding website accessibility, however, the World Wide Web Consortium created Web Content Accessibility Guidelines (WCAG) as a resource to meet the vague standard of “reasonably accessible.” WCAG is not adopted as the federal standard of accessibility, only best practices mainly for visual impairment. The Department of Justice has not provided clear guidance or rules on how to be 100% compliant, providing flexibility for private businesses to improve website accessibility. However, the vague standards open the door for claims that a website isn’t accessible enough.

Below are some highlights from a recent webinar which discussed compliance strategies to mitigate risks. This article is for informational purposes only and should not be construed as legal advice. Claims typically brought:

- Website lacks alternative text tabs
- Alternative text tabs have insufficient descriptions
- Keyboard Navigation in not functional
- Contract issues on text
- Video content lacks closed captioning

The following measures can increase accessibility for your website, which are vulnerable to litigation.

Screen reader software is used to read aloud plain text on a website, but the software cannot read items like images, links, buttons, forms, or headers. Alternative Text Descriptions (Alt Tags) are added in source code to describe an item which cannot be natively read by screen readers. Alt Tags should include context within the page with a basic description relevant to what the item is trying to convey. Free audit tools like WAVE can help you identify accessibility issues for Alt Tags.

Keyboard navigation is used to navigate websites rather than a mouse. The “enter” key gets you into links, the “tab” key jumps from header to header, and special command plus right, left, up, down, arrows allow you to scan line by line on a website. You can go into your website and test accessibility keeping in mind: Does your keyboard get stuck anywhere on the page or are there places your keyboard cannot get into? The most vulnerable areas are template portions, homepages, pop-ups, and contact pages. Accessible Rich Internet Applications (ARIA) attributes can be added to remedy navigation issues.

Video content needs closed captioning. Whenever you embed a video on your website, make sure you do not lose the closed captioning option. Video content without sound or dialog does not require caption but you can include a note “video above contains no sound.”

Ensure new content is updated with accessibility capabilities of screen readers, keyboard navigation, and closed captioning to avoid claims. Your websites should have an accessibility statement as html text, including an email and phone number for complaints. Although tools exist, manual auditing is the best way to check and update compliance.

INDUSTRY INSIGHTS

Federal Government Suspends Funding for New York’s Medicaid Fraud Control Unit

by Al Conti, Conti Consulting Services

The US Department of Health and Human Services (HHS) Office of Inspector General (OIG) has suspended federal grant funding for New York State's Medicaid Fraud Control Unit (MFCU / the Unit) from July 1 through the end of the grant period, September 30, 2026, unless the state’s MFCU can show sufficient corrective action before that date.

The suspension follows a targeted onsite review conducted during the week of June 8, 2026, after which HHS OIG concluded that New York's unit underperformed when compared with similarly sized MFCUs in California, Texas, Ohio, and Florida. According to HHS, New York recorded the fewest criminal fraud indictments and convictions among those states during the 2023-2025 review period.

The HHS review examined staffing levels, referrals, case progression, criminal indictments, fraud convictions, recoveries, and overall program performance. Based on those findings, HHS directed the state to develop corrective action plans within 30 days in several areas, including:

- Rebalancing staffing resources to better support fraud investigations and patient abuse and neglect cases.
- Increasing referrals to the MFCU through a root cause analysis and measurable improvement plan.

- Improving case progression to ensure investigations move forward in a timely manner.
- Strengthening coordination with the HHS Office of Inspector General through regular meetings and updated policies and procedures.

New York officials have strongly disputed the federal government's conclusions. Attorney General Letitia James stated that New York's MFCU has long been recognized as a national leader in combating Medicaid fraud and argued that the Unit prioritizes large, complex corporate fraud cases that generate significant recoveries rather than pursuing a higher volume of smaller criminal prosecutions. State officials have indicated they are considering legal action to challenge the funding suspension.

What This Means for Providers

While the suspension affects only the federal funding of New York's Medicaid Fraud Control Unit and does not impact Medicaid reimbursement to providers, agencies should anticipate continued, and potentially heightened, program integrity oversight as the state works to demonstrate effective fraud prevention and enforcement.

Providers should continue to maintain compliance programs that meet OMIG requirements, including regular auditing and monitoring, governing board oversight, annual compliance training, and an up-to-date compliance work plan. Agencies should also remain prepared for medical record reviews, Compliance Program Review Module (Mod-5) assessments, and Electronic Visit Verification (EVV) audits, all of which continue to be areas of focus for OMIG.

NOTES FROM THE FIELD

Member Inquiries & Findings

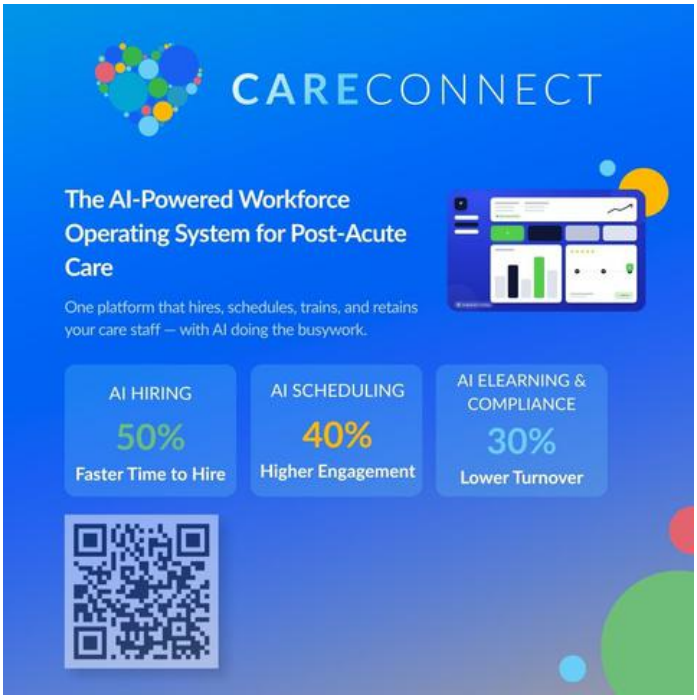
HCP is a resource for members who need clarification on laws, rules, and regulations. If you need support understanding the nuances of home care services in New York State, email publicpolicy@nyshcp.org and staff will investigate, outreaching to the Department to Health (DOH / the Department) when needed, to provide insight and interpretation to support your business. Below are a few of the inquiries we've received which may be beneficial to Licensed Home Care Services Agencies (LHCSA).

Can relatives be Personal Care Aides or Home Health Aides (PCA/HHA)?

- The Department of Social Services rules outline who may be compensated for personal care services for a relative. A patient's spouse, parent, son or son-in-law, daughter or daughter-in-law **cannot** serve as PCA/HHA. However, other relatives can as long as they:
  - Are not residing in the patient's home; or
  - Are residing in the patient's home because the amount of care required by the patient makes presence necessary.
- NYSRR Title 18, Chapter II, Subchapter E, Article 3, Part 505.14 Personal care services (h)(2).

How can LHCSAs seek remedy for unpaid claims?

- Non-payment falls under Prompt Payment Insurance Law and should be brought to the Department of Financial Services (DFS) by filing a complaint under the Healthcare Provider Complaint application in the DFS portal.
- Once you receive a case number, HCP can follow up with the head of the department/Consumer Assistance Unit to expedite the investigation.



Where can you find recorded Department of Health webinars?

The material will be uploaded to the New York Learns Public Health Learning Management System. Create a login to access the recorded webinar. It can take some time for the department to upload the material so check regularly for updated material.

Who is a member of HCP, where do they serve and what can they provide?

Access HCP's Find a Home Care Agency tool and Vendor Directory on our website.

HCP | NYS Association of Health Care Providers
Representing Home & Community-Based Care

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I ♥ HOME CARE

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