STATE OF NEW YORK

10506

IN ASSEMBLY

March 6, 2026

Introduced by M. of A. PAULIN -- read once and referred to the Committee on Health

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 six new subdivisions 5, 6, 7, 8, 9 and 10 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 paragraph (a) of this subdivision. If the commissioner chooses to exercise this option, the minimum rate identified in paragraph (a) of this subdivision 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 subdivision five of this section.

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

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(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 subdivision five of this section in a report to the department. Such 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 subdivision 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 subdivision five of this section 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 subdivision 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.