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The Honorable Kathy Hochul
Governor of New York
NYS State Capitol Building
Albany, NY 12224

Re: Department of Health and Human Services claims of Fraud, Waste, and Abuse in Personal Care Services

Dear Governor Hochul:

The New York State Association of Health Care Providers (HCP) is a statewide trade association that supports and advocates for Licensed Home Care Services Agencies (LHCSAs) through education, representation, and member services. We write in support of New York State's meaningful efforts to contain fraud, waste, and abuse (FWA) in the state's Personal Care Services (PCS) Medicaid program and to emphasize the importance of considering these efforts in the context of New York's strong commitment to the provisions of accessible, high quality, and comprehensively regulated provider and service delivery systems.

New York demonstrates a strong commitment to Medicaid long-term care through its level of investment in the program and pledge to provide access to community-based services to New Yorkers. It is far too simplistic, however, to treat New York's level of investment, relative to other states, as proof of fraud, waste, or abuse, particularly given the rigorous oversight imposed on personal care providers by multiple state agencies. A more complete explanation is that New York has made longstanding policy decisions to support broader access to home and community-based services (HCBS) because home is the setting most people prefer and home-based care can prevent or delay costlier institutional placement.

Equally important is an accurate understanding of how the system functions. Medicaid personal care services are provided through contracts with LHCSAs, which are subject to licensure and regulatory minimum standards set by the New York State Department of Health (DOH). At times, LHCSAs appear to be the focus of concern for the growing utilization in the personal care program. LHCSAs, however, do not determine who receives services or in what amount. Eligibility and authorization decisions are made through independent assessment processes and by payors. Any analysis that does not account for this structure risks drawing incorrect conclusions about utilization and spending patterns.

To support that understanding, we offer the following context regarding program structure, oversight, and data interpretation as state leaders consider the assertions made in the March 3, 2026, Centers for Medicare and Medicaid Services (CMS) letter requesting information on program integrity, provider screening, and enrollment oversight in the New York State Medicaid

program. While the inquiry spans multiple service types, our comments are limited to personal care services provided by licensed home care services agencies.

New York's approach to home and community-based services reflects both deliberate policy choices and a strong regulatory framework. Licensed home care services agencies, the primary providers of personal care services in the state, are a highly scrutinized and tightly regulated sector of the health care system, with extensive oversight, auditing, and reporting requirements designed to ensure program integrity and the responsible use of public funds.

This structure is grounded in longstanding federal and state policy. The Olmstead decision affirmed the right of individuals to receive services in the least restrictive setting appropriate to their needs, and the HCBS Settings Rule reinforces that emphasis on integration and community-based care. New York has consistently aligned its Medicaid policies with these principles, prioritizing access to services that allow individuals to remain safely in their homes and communities.

Program Structure and Oversight

When a potential recipient of Medicaid funded, home-based long term care services enters the HCBS system, they interact with numerous "gatekeepers" before they are determined eligible to receive personal care services.

Individuals are first determined to be financially eligible for Medicaid. Once Medicaid eligible, if home care services are needed, individuals undergo an independent assessment through the New York Independent Assessor (NYIA), which determines eligibility for Medicaid personal care services and helps them connect with an appropriate managed care plan (MCO) to secure such care. The individual's MCO, likely a Managed Long Term Care (MLTC) or Medicaid Advantage Plus (MAP) insurance plan or in limited cases their Local District Social Services (LDSS) office determines the level and amount of authorized care. The authorized hours for personal care services are then shared with the LHCSA, which then assesses the individual and develops a person-centered plan of care based on the authorized hours of service. This separation of assessment, authorization, and service delivery is a core safeguard within the system.

Once services are initiated, LHCSAs are subject to extensive oversight from the New York State Department of Health (DOH/the Department) and the Office of the Medicaid Inspector General (OMIG). Documentation requirements are detailed and continuous, and OMIG audit practices include extrapolation methodologies that reinforce billing accuracy and compliance.

Providers are also responsible for maintaining strict workforce standards. Personal care aides are subject to Criminal History Record Checks (CHRC), fingerprinting, home care registry verification, and ongoing training, supervision, health and safety, and competency requirements. Employers must also conduct regular screenings against state and federal exclusion lists.

A complete analysis of program integrity must account for how eligibility and service authorization decisions are made within New York's Medicaid structure. Providers deliver and bill only for services that have been authorized through this process.

Recent public commentary has reflected misunderstandings about how eligibility and service delivery intersect across HCBS programs. For example, adult day care programs do not determine eligibility for personal care services, nor do they authorize hours of care. Individuals may be enrolled in multiple services to meet distinct needs, but each service is governed by its own authorization and oversight structure, which exists outside of the control of LHCSAs.

CMS Data and Recent Reporting

Key context for interpreting the data:

The Department of Health and Human Services (HHS) has cited instances of fraud within HCBS programs. Isolated cases within a large and complex health care system are not indicative of systemic issues within a specific provider sector.

Review of FWA must be understood in the context of workforce scale. Personal care and home health aides represent a substantial share of the health care workforce, both nationally and in New York. Higher numbers due to a larger workforce do not mean fraud is more common.

CMS has also suggested that a significant portion of New York's Medicaid population receives personal care services. Available data suggests this may reflect a misinterpretation of enrollment versus utilization. The majority of Medicaid beneficiaries do not use long-term services and supports. By contrast, [research based on CMS claims data](#) indicates that a relatively small percentage of beneficiaries over age 65 receive personal care services, a rate that is comparable to or lower than other states analyzed.

New York's HCBS landscape also includes a mix of service delivery models, including both agency-directed and self-directed care. These models reflect patient preference for autonomy and flexibility, particularly among individuals managing long-term needs in the home. The presence of multiple service models within the system further underscores the complexity and importance of evaluating utilization and spending patterns within the full context of program design, rather than attributing variation to provider behavior alone.

Personal care spending is also influenced by patient need. Individuals receiving these services often have multiple chronic conditions and require long-term, labor-intensive support. As a result, a relatively small population accounts for a significant share of total spending.

Provider Screening, Enrollment, and Compliance

New York's Article 36 licensure structure establishes rigorous standards for home care providers. LHCSAs must obtain approval from the Public Health and Health Planning Council (PHHPC), demonstrating financial stability, operational readiness, and community need. Providers are subject to continuous regulatory oversight, including DOH surveys, OMIG audits, compliance program requirements, and self-disclosure obligations. Electronic Visit Verification (EVV) systems further support program integrity by linking service delivery to claims submission.

Billing Controls and Program Safeguards

What program integrity looks like in practice:

- Eligibility is determined independently through NYIA
- Service hours are authorized by MLTC plans or LDSS
- Providers bill only for authorized and delivered services
- Documentation standards are extensive and subject to audit
- OMIG audit practices include extrapolation and recoupment
- EVV systems provide multiple layers of verification
- Workforce screening includes CHRC, registry verification, and exclusion checks

Workforce and Utilization Trends

What's driving growth in personal care:

Demand for home care services continues to rise due to demographic trends, including an aging population, people living longer with more chronic conditions, and increasing preference for care in the home. Personal care aide roles have a relatively low barrier to entry compared to other health care professions, allowing the workforce to expand more rapidly in response to demand.

Growth in this workforce reflects these structural factors and labor market dynamics. It does not, in itself, indicate fraud or misuse of services.

Conclusion

New York's investment in home and community-based services reflects a deliberate policy commitment to supporting individuals in their homes, where they overwhelmingly prefer to receive care and where care can often be delivered more cost-effectively than in institutional settings.

New York's providers operate under significant regulatory scrutiny and are subject to frequent audits, detailed documentation requirements, and strict compliance standards. While no system is immune to bad actors, isolated instances should not be mistaken for systemic failure.

A meaningful approach to program integrity must consider the full continuum of decision-making within the system, including assessment, authorization, and service delivery. Without that perspective, efforts to identify fraud, waste, and abuse risk targeting the wrong levers and missing opportunities for meaningful improvement.

HCP is ready to engage, share insight, and collaborate on ways to strengthen the Medicaid program and promote a more accurate understanding of the issues. We welcome the opportunity to work together on these shared goals.

Sincerely,

Kevin Thomas
President

cc: James V. McDonald, MD, MPH

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