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USA – New York: Trends and Developments

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USA – NEW YORK



Trends and Developments

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including: healthcare compliance and counselling guidance, contracts, HIPAA and medical record privacy, reimbursements, healthcare transactions and finance, life sciences and health effects, including pharmaceuticals, medical devices, psychedelics and mental health therapeutics. We also handle healthcare litigation and investigations in matters involving fraud and abuse, false claims, contract disputes, reimbursement challenges and licensure and credentialing disputes.

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New York State's healthcare sector remains diverse and fragmented, encompassing large integrated health systems, safety net hospitals, academic medical centres, independent physician practices, behavioural health providers, home care agencies and an expanding ecosystem of technology enabled services. Financial pressure persists across many segments, driven by:

- labour shortages;
- inflationary operating costs;
- reimbursement constraints;
- cybersecurity investment demands; and
- ageing infrastructure.

These pressures continue to incentivise affiliation, consolidation and capital partnership strategies, even as regulatory scrutiny has intensified.

While New York's healthcare transaction volume remains below the historical highs observed in 2020–2021, many market participants perceive:

- greater stability in financing conditions;
- a modest improvement in asset quality; and
- increased alignment between buyer and seller valuation expectations.

At the same time, deal making continues in one of the most regulated healthcare environments in the U.S., requiring careful planning, extended timelines and conservative structuring.

Core Market Drivers

The principal drivers of healthcare transactional activity in New York entering 2026 largely mirror those shaping the national market, while exhibiting certain state specific features.

First, ongoing financial strain among hospitals and institutional providers, especially safety-net and community hospitals, remains a significant catalyst. These organisations face persistent workforce shortages, rising wage pressure, constrained Medicaid and Medicare reimbursement and increased capital needs for technology, facilities and cybersecurity. Such pressures may be exacerbated in rural areas of New York. Strategic combinations, asset sales and management affiliations are often pursued as mechanisms to stabilise operations, access capital and preserve services.

Second, physician practice consolidation continues across multiple specialities. Independent practices increasingly seek scale to:

- manage administrative burden;
- negotiate payer arrangements;
- invest in technology; and
- address physician succession challenges.

New York's corporate practice of medicine doctrine and related professional ownership rules continue to influence transaction structures, often leading to management services organisation (MSO) models, minority investment strategies or staged acquisitions rather than outright equity transfers.

Third, behavioural health and substance use disorder services remain areas of sustained demand and investment interest. Despite ongoing challenges related to reimbursement complexity and workforce shortages, outpatient mental health, addiction treatment and integrated behavioural health models remain highly attractive to both strategic buyers and financial sponsors.

Fourth, the continued migration of care to outpatient and home based settings remains a major strategic driver. Ambulatory surgery centres, diagnostic services, home health and hospice settings continue to benefit from payer cost containment strategies and patient preferences for lower acuity care settings.

Finally, technology enabled healthcare services (ie, telehealth, revenue cycle management, patient access solutions, workforce optimisation and data analytics) have become increasingly important in transaction strategies, particularly those that incorporate artificial intelligence.

The following sections highlight important, New York-specific regulatory considerations for stakeholders involved with healthcare transactions in New York that continue to impact the transaction structure. These regulatory influences and associated compliance undertakings will vary depending on the structure and size of the transaction and on the specific type of entity or entities involved.

State Oversight

The New York State Department of Health (NYSDOH) is the state body with primary regulatory authority over the delivery of healthcare services in New York. Several other state bodies also shape New York State's healthcare regulatory scheme, including the New York State Education Department, which currently authorises and oversees individual professional licensees in New York*, and the New York State Department of Financial Services, which regulates various types of health insurers and managed care providers operating in New York.

Healthcare services in New York are primarily rendered through the following two general categories of entities:

- facilities issued operating certificates by the NYSDOH, including hospitals, ambulatory surgery centres and nursing homes; and
- professional services entities (professional service corporations (PCs), professional service limited liability companies (PLLCs) and registered professional limited liability partnerships (PLLPs)).

Stakeholders in a transaction involving a New York healthcare entity or entities must consider the identity and regulatory profile of the entity or entities, including its existing licenses, registrations, service lines and financial relationships. For example, stakeholders must know:

- the types of services the entity provides;
- the licenses and registrations the entity holds or must hold; and
- who may legally own or control the entity.

Such knowledge is a pivotal threshold for developing a transaction strategy and navigating the potential regulatory influences on the transactions described below.

Material Transaction Review

Regulatory oversight over transactions involving New York healthcare entities continues to evolve. In response to the growth of private equity involvement in the healthcare industry, the state has taken active steps in recent years to increase its scrutiny of certain healthcare transactions and their impact on cost, quality and access to care.

New York's Disclosure of Material Transactions Law, codified under New York Public Health Law Article 45-A, became effective 1 August 2023 and requires "healthcare entities" involved in "material transaction(s)" to provide written notice to NYSDOH at least 30 days prior to the closing of the transaction. Notices of a material transaction must be reported electronically using the [Material Transaction Reporting Form](#). The form requires information about the parties to the transaction, pre-closing and post-closing organisational charts and the anticipated impact of the transaction on care quality and access to care. Failure to provide the required 30-day notice under

Article 45-A subjects healthcare entities to daily fines under the New York Public Health Law.

The NYSDOH publishes filed information on proposed transactions on its website for notice and public comment. Article 45-A does not grant the NYSDOH the right to approve or deny material transactions. The NYSDOH also provides a copy of the proposed transaction notice to the Office of the New York State General, which may lead to additional scrutiny, particularly if the proposed transaction raises antitrust concerns or impacts the use of charitable funds by a not-for-profit corporation involved in the transaction.

Under Article 45-A, “healthcare entity” includes, but is not limited to, a physician practice or group, MSO or similar entity that provides all or substantially all administrative or management services under contract with at least one physician practice, provider-sponsored organisation, health insurance plan and any other kind of healthcare facility organisation or plan that provides healthcare services in New York State. The NYSDOH has advised that the following entities are also considered “healthcare entities”:

- dental practices;
- clinical laboratories;
- pharmacies;
- independent practice associations; and
- accountable care organisations.

Article 45-A defines “material transaction” as any of the following that occur during a single transaction or in a series of related transactions within a rolling 12-month period that result in a healthcare entity increasing its total gross in-state revenues by USD25 million or more:

- a merger of one or more healthcare entities;
- an acquisition of one or more healthcare entities, including the assignment, sale or other conveyance of assets, voting securities, membership or partnership interests or the transfer of control, such as contracting for services commonly provided through a management or administrative services agreement between a practice and an MSO;

- an affiliation agreement or contract formed between a healthcare entity and another person; and
- the formation of a partnership, joint venture, accountable care organisation, parent organisation or MSO for the purpose of administering contracts with health plans, third-party administrators, pharmacy benefit managers or healthcare providers.

Article 45-A does not apply to insurers or pharmacy benefit managers already subject to regulation by the New York State Department of Financial Services. In addition, the following transactions are not considered material and are exempt from Article 45-A’s notice requirement:

- clinical affiliation of healthcare entities formed for the purpose of collaborating on clinical trials or graduate medical education programmes; and
- any transactions already subject to the NYSDOH’s Certificate of Need (CON) process or an insurance-entity approval process under New York State Public Health Law Articles 28, 30, 36, 40, 44, 46, 46-A or 46-B.

Governor Kathy Hochul’s FY 2026-2027 budget proposal included the following proposed amendments to Article 45-A:

- two additional disclosures to be submitted with the initial material transaction notice, which are:
 - (a) a statement indicating whether any party to the transaction or any person with control over the healthcare entity, has closed operations, is in the process of closing operations or has experienced a substantial reduction in services within the past three years; and
 - (b) a statement as to whether any sale-leaseback, mortgage or other financing arrangement is a component of the transaction, as well as copies of the applicable documents;
- parties to a material transaction must provide the NYSDOH annually, for a five-year period post-closing, information necessary to evaluate the transaction’s impacts on cost, quality, access, health equity and competition and
- the NYSDOH would have the authority to conduct a preliminary review of all proposed material trans-

actions and for transactions valued at USD100 million or more, would permit the NYSDOH to conduct a full cost and market impact analysis. Such analysis could potentially delay transaction closings by up to 180 days.

If enacted, the amendments will take effect one year after enactment.

Certificate of Need

The NYSDOH's CON process regulates the following:

- establishment, construction or renovation of facilities licensed by the NYSDOH pursuant to the New York Public Health Law;
- the acquisition of major medical equipment for such facilities;
- the addition, elimination or modifications of services and service areas by such facilities; and
- changes in ownership of such facilities.

CON review and approval are necessary steps for these types of modifications and involve an extensive, time-intensive review of certain factors related to public need, financial feasibility and the character and competence of governing bodies of facilities subject to review.

The scope of such a review varies depending on the specific action proposed. For example, the establishment of a new acute hospital requires a full CON review, while hospital renovations costing USD15 million or less require only a limited CON review.

Stakeholders in transactions involving facilities licensed or to be licensed, under the New York Public Health Law must be aware of any applicable CON requirements and, if a CON review is required, should account for NYSDOH review times in their transaction timelines.

New York State Fraud and Abuse Laws: Transactional Implications

In addition to federal fraud and abuse statutes such as the Anti Kickback Statute and Physician Self-Referral Law (Stark Law), healthcare transactions in New York must account for state-specific fraud and abuse laws, which operate alongside, but are not identical to, their

federal counterparts and can materially affect deal structuring and diligence.

For example, New York's practitioner self-referral law, set forth in Public Health Law § 238-a, prohibits a "practitioner" authorised to order clinical laboratory, pharmacy, radiation therapy, physical therapy or x-ray/imaging services from referring a patient for those services to any healthcare provider with whom the practitioner or their immediate family member has a financial relationship. Under the law, "practitioner" means a licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife, physician assistant, specialist assistant, physical therapist or optometrist. The statute also prohibits billing for services furnished pursuant to a prohibited referral and broadly defines financial relationships to include both ownership and compensation arrangements.

The self-referral prohibition in Section 238-a applies to all payors, not just government payors. Combined with the broader definition of "practitioner" under Section 238-a and the fact that there are fewer regulatory exceptions available under Section 238-a than under the federal Stark Law, Section 238-a arguably presents a more stringent compliance standard than its federal counterpart. Therefore, diligence in transactions involving physician practices or other "practitioner" practices requires a compliance review of both federal and state laws.

New York also has several laws prohibiting similar conduct as the federal Anti-Kickback Statute, including Social Services Law Section 366-d(2), which prohibits the exchange of remuneration for referring items or services payable by the New York State Medicaid programme.

New York False Claims Act

New York's False Claims Act (NYFCA) provides an independent state enforcement mechanism targeting false or fraudulent claims submitted to the Medicaid programme and other state healthcare programmes. The statute authorises treble damages, penalties and qui tam whistleblower actions, making it a significant diligence and post closing risk consideration.

From a transactional perspective, NYFCA exposure underscores the importance of thorough billing and coding diligence, historical audits, repayment obligations and the maturity of a compliance programme. Buyers frequently focus on:

- Medicaid billing practices;
- documentation standards; and
- historical interactions with state oversight agencies.

Corporate Practice of Medicine, Fee Splitting and Professional Discipline

New York is one of several states that prohibit the corporate practice of medicine and forbid non-physicians from owning or controlling medical practices. Although facilities such as hospitals, ambulatory surgery centres and nursing homes can offer healthcare services under a NYSDOH-issued license – and may be owned or controlled by non-licensed individuals – professional medical services in New York must otherwise be provided solely by licensed physicians, either individually or through PCs, PLLCs or similar professional entities. Such entities may only be owned and controlled by licensed physicians.

Further, New York's fee-splitting prohibition prevents a physician from permitting any non-physician or an unaffiliated physician, to share in fees received by the physician for rendering professional services. This prohibition includes any arrangement or agreement whereby the amount received by the non-professional or unaffiliated physician constitutes a percentage of or is otherwise dependent upon, the income or receipts of the licensed physician derived from providing professional services.

The purpose of this regulatory scheme is to maintain physicians' independent decision-making authority and prevent undue influence on their delivery of patient care. In compliance with this regulatory scheme, physician practices may partner with MSOs to provide certain non-clinical, management or administrative services in exchange for a fee. If not structured properly to preserve the independent professional judgment of licensed physicians, MSO/physician practice arrangements risk:

- the MSO and its owners being deemed to engage in the unauthorised practice of medicine; and
- participating physicians being subject to professional discipline for aiding or abetting professional misconduct.

Any MSO/physician practice arrangement or similar arrangement involving physician practices, must:

- be structured to preserve physicians' professional independence;
 - limit non clinical control rights; and
 - comply with ownership and governance requirements.
- In addition, the MSO's compensation must be structured to comply with New York's prohibition on fee-splitting.

Non-Compete Agreements

New York proposed, but did not enact, similar legislation to the Federal Trade Commission's (FTC) proposed non-compete ban in 2024. New York legislators have since revived efforts to ban or otherwise limit employers' use of non-compete clauses in employment contracts, including a specific proposal to limit their use for healthcare professionals (Senate Bill 9228).

Monitoring this proposed legislation restricting non compete agreements for healthcare professionals will be increasingly important, particularly for transactions employing MSO/physician practice structures. If enacted, such legislation could materially affect the use of physician restrictive covenants that have traditionally supported platform stability and valuation. In combination with the heightened oversight and transparency requirements under Article 45 A, these developments may prompt investors and sponsors to re evaluate structuring and value protection strategies in physician led transactions.

Impact on Deal Structuring and Diligence

Collectively, the foregoing regulatory considerations reinforce a transactional environment characterised by disciplined diligence and conservative structuring.

Buyers remain focused on compliance history, billing integrity, referral relationships, licensure status, cyber-

security readiness and regulatory interaction history as core valuation drivers.

Deal documentation increasingly includes:

- extended outside dates;
- bespoke regulatory termination rights;
- detailed compliance covenants; and
- post closing reporting obligations.

Minority investments, staged acquisitions, joint ventures and operational partnerships continue to be employed as alternatives to full-control transactions, particularly when approval timing or regulatory risk is uncertain.

Outlook for 2026 and Recommendations for Transaction Stakeholders

Despite existing regulatory constraints, healthcare transactional activity in New York continues across multiple subsectors, including physician services, behavioural health, home care, ambulatory services and healthcare technology enabled platforms. In evaluating a healthcare transaction in New York, providers, investors, health systems and other transaction stakeholders should heed the points outlined below.

Know the healthcare entity involved in the transaction. This is a crucial initial step to determine which regulatory notices, filings and approvals are required for the transaction to close and the level of risk (and the accompanying diligence needed to evaluate it).

Knowing the healthcare entity involved in the transaction also helps create reasonable closing timing expectations between the parties involved in the transaction. As discussed, New York's regulatory scheme operates differently depending on the type of entity involved and the size of the transaction.

As demonstrated by the proposed legislation referenced herein, New York's healthcare regulatory landscape continually evolves, with heightened focus on limiting factors that, in the eyes of the State of New York, detrimentally impact access to care, the cost of care and care quality. Regulatory changes should be monitored and factored into any transaction strategy.

* Governor Kathy Hochul's Fiscal Year 2026-2027 budget includes proposed amendments to the New York State Education Law and Public Health Law that would transfer regulatory oversight of physicians, physician assistants and specialist assistants from the New York State Education Department to the NYS-DOH. If enacted, these changes will take effect on 1 January 2027.

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