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Healthcare Alert

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Select health-related provisions in New York's FY 2026–2027 budget bill

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New NY budget reshapes surprise billing, staffing agency rules, and MCO taxes, while sidelining certain healthcare reforms.



What's the impact?

- The enacted HMH bill exempts Medicaid Managed Care from New York's Surprise Billing IDR process and folds in the New York State Health Insurance Program (NYSHIP).
- NYSDOH gains authority to cap profits of temporary health care services agencies, and the definition of "temporary health care services agency" is broadened to encompass entities operating through vendor management systems and subcontracting arrangements.
- Excluded Executive proposals: Expanded oversight of material healthcare transactions; healthcare workforce scope-of-practice expansions; transfer of licensing authority from NYSED to NYSDOH; and a joint OASAS-OMH behavioral health licensing framework.

On May 28, 2026, after a lengthy delay, New York State enacted the Health and Mental Hygiene (HMH) bill—one of several bills that collectively comprise New York State's 2026–27 budget

legislation. Below we summarize the key enacted provisions affecting healthcare providers, payers, and staffing agencies, as well as notable proposals from the Governor's Executive Budget that were omitted.

What was enacted

CHANGES TO NEW YORK'S SURPRISE BILLING LAW (PART BB)

Part BB amends New York's independent dispute resolution (IDR) framework in several important ways:

- / **Medicaid carve-out.** The IDR statute will no longer apply to healthcare services, including emergency services, covered by the NYS Medicaid Program. This effectively means that Medicaid Managed Care payers will not be subject to the IDR process and payment standards that apply to commercial and other payers. Practices and providers for which Medicaid enrollees make up a substantial portion of their patient population will be adversely affected.
- / **NYSHIP inclusion with special rules.** The New York State Health Insurance Program (NYSHIP)—the insurer for most state civil servants—is now subject to the IDR process, but with its own decision standard. The statute defines an “allowed benchmark” (the 50th percentile of all allowed amounts for a particular service by a participating provider in the same or similar specialty in the same geographic area) and a “maximum fee” (the 80th percentile of such amounts). As a default, the IDR entity must select the payment or fee closest to the allowed benchmark, and in no event may the amount owed by a healthcare plan exceed the maximum fee. However, the IDR entity may depart from the benchmark if the parties' submissions are equally distant from it, or if factors such as the provider's training and experience, the complexity of the case, or individual patient characteristics clearly demonstrate that the benchmark is not the appropriate payment. When the IDR entity departs from the benchmark, it must provide a written explanation. Notably, the IDR entity may **not** base a departure on gross disparity in fees, the provider's usual charges, or the usual and customary cost of the service.
- / **Hospital physician exception.** Notwithstanding the NYSHIP-specific framework, disputes involving physicians employed by a general hospital (or its affiliated medical school), or who are part of a captive professional services corporation whose shareholders are employees of such hospital, remain subject to the general IDR standard—even if the services are paid for by NYSHIP. This exception is significant for academic medical centers and hospital-based physician groups.
- / **Upfront payment for IDR.** Both parties must now submit full payment for the dispute

resolution process—the filing party upon submission of the application, and the responding party when responding to the IDR entity’s request for eligibility information and supporting documentation. The IDR entity must hold payments in a separate account and refund the prevailing party within 30 days of rendering a determination.

- / **Extended determination timeline.** The time period for an IDR entity to make determinations has been extended from 30 to **45 business days** of receipt of all information the entity determines it needs to review.
- / **Governor’s broader IDR reforms rejected.** The Governor had introduced more substantial reforms to the IDR statutes, but those changes were rejected by the Legislature.
- / **Effective date.** Although certain changes took effect immediately upon enactment, several significant provisions will not take effect until **August 26, 2026** (90 days after enactment).

TEMPORARY HEALTH CARE SERVICES AGENCIES (PART J)

Part J amends Article 29-K of the Public Health Law governing temporary health care services agencies. The key changes include:

- / **Profit cap authority.** NYSDOH is granted authority to promulgate regulations establishing, monitoring, and enforcing a limitation on the amount that temporary health care services agencies “may retain as profit” (the “agency rate”). Agency rates may be expressed as a percentage or in another manner as determined by NYSDOH. In setting rates, NYSDOH must consider factors including the ability to maintain sufficient staffing across all geographic areas, and must engage in periodic reassessment to ensure rates reflect current conditions.
- / **Expanded definition.** The definition of “temporary health care services agency” now includes persons and entities that “indirectly” engage individuals to perform health care services, and specifically encompasses businesses using “vendor management systems and subcontracting arrangements.” This amendment forecloses any argument that an entity operating through such arrangements falls outside the statute’s reach.
- / **Subcontractor requirements.** Agencies that subcontract their services must require subcontractors to include all of the same contract provisions (minimum licensing, advance notice, rate disclosure, complaint procedures, etc.) in their agreements with health care entities. Agencies must retain subcontracts for six years and make them available to NYSDOH upon request.
- / **Worker fee prohibition.** Temporary health care services agencies may not require payment of fees or other compensation from individual workers for placement or connection with a health care entity.
- / **Enhanced reporting.** Quarterly reporting requirements have been clarified and now include the names of subcontractors.

/ **Effective date.** Part J takes effect one year after enactment (May 28, 2027), although NYSDOH may publish regulations before then.

MCO PROVIDER TAX (PART Y)

Part Y amends the MCO provider tax statute at Public Health Law § 2807-ff. Subject to CMS approval, effective January 1, 2027, health plans will pay the MCO provider tax at a rate of **0.35% of total premium revenue** for each calendar year. This replaces the current tiered per-member-per-month rate structure that varies based on member month volume and plan type.

What didn't make it in

Several proposals in the Governor's 2026–2027 Executive Budget were excluded from the enacted bill. While these provisions did not advance this session, they may resurface in future legislative cycles.

EXPANDED OVERSIGHT OF MATERIAL HEALTHCARE TRANSACTIONS (PART H)

For the second consecutive year, the enacted budget did not adopt changes to Article 45-A of the Public Health Law governing material healthcare transaction notice requirements. If adopted, the proposal would have significantly expanded disclosure obligations in several ways, bringing New York's material transaction law closer to that of states such as California and Massachusetts. NYSDOH would have been authorized to conduct a preliminary review of every notice filed and could have ordered a full Cost and Market Impact Review (CMIR) for any transaction valued at \$100 million or more, as well as for smaller transactions that NYSDOH believed could adversely affect cost, quality, access, health equity, or competition. Parties would also have been required to submit post-closing disclosures, including annual reports for five years addressing the transaction's impact on those same factors.

HEALTHCARE WORKFORCE EXPANSION AND REGULATORY REALIGNMENT (PART N)

The Budget did not expand the scope of practice for several categories of healthcare workers, including medical assistants and physician assistants (PAs). Omitted proposals would have permitted medical assistants to administer vaccines in physician offices under direct supervision and would have allowed PAs with more than 8,000 hours of practice in the same or a substantially similar specialty to practice without physician supervision in qualifying settings, such as rural emergency hospitals, general hospitals, non-surgical diagnostic and treatment centers, and primary care practices.

Also, the enacted budget yet again omitted the Governor's proposal to transfer licensing authority for medical professionals from the New York State Education Department (NYSED) to NYSDOH.

UNIFIED LICENSING FOR INTEGRATED BEHAVIORAL HEALTH SERVICES (PART Q)

The budget omitted a proposal to establish a joint licensing framework for “Integrated Behavioral Health Services” programs. This proposal would have allowed certain providers with experience in both mental health and substance use disorder services to deliver coordinated treatment under a single license issued jointly by the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS). If adopted, OMH and OASAS would have been authorized to issue joint regulations establishing licensing standards, scope of services, staffing, billing and reimbursement, utilization review, patient rights, and incident reporting. With Part Q omitted, mental health and substance use disorder service providers will continue to navigate the existing dual-licensure structure and be required to comply with the requirements of both New York agencies.

Looking ahead

As is to be expected, the enacted HMM bill reflects a narrower set of reforms than the Governor originally proposed. Many of the omitted provisions—particularly the expanded oversight of material healthcare transactions and the transfer of medical licensing authority to NYSDOH—have appeared in multiple budget cycles and may be reintroduced. Healthcare providers, payers, and staffing agencies should monitor developments as the Legislature and NYSDOH turn to implementation and rulemaking.

For questions about how these provisions may affect your organization, please contact your Nixon Peabody attorney or:

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