AMERICAN HEALTH LAW ASSOCIATION

HEALTH LAW WEEKLY
April 24, 2026

Medicaid Plan M&A: Navigating an Increasingly Complex State Environment

Alice Hall-Partyka, Crowell & Moring LLP

Melissa Moravec, Crowell & Moring LLP

Paul Mourning, Crowell & Moring LLP

Katy Raffensperger, Crowell & Moring LLP

As financial headwinds continue to intensify in 2026, managed care companies are beginning to weigh their strategic options with respect to their Medicaid lines of business, including potential sales, contractual affiliations, and joint ventures. These conditions are expected to generate a meaningful uptick in Medicaid plan-related merger and acquisition (M&A) activity during and beyond 2026. Aspiring purchasers, however, should approach the opportunity with clear eyes: acquisitions in this space are considerably more complicated than they might anticipate. Over the past several years, several states—with Oregon and California standing as notable frontrunners—have made significant, intentional strides to regulate health care consolidation, creating new requirements, procedural hurdles, and substantive restrictions that both buyers and sellers need to navigate carefully when engaging in these types of transactions.

Organizations that approach these potential strategic transactions with rigorous regulatory preparation, deliberately structured transaction plans, and cogent narratives tailored to the expectations of relevant reviewing bodies will be best positioned to execute successfully in what promises to be one of the most consequential periods of dealmaking the Medicaid managed care market has seen in years.

Medicaid M&A: Anticipating a Boom in (and Beyond) 2026

The financial logic ushering Medicaid managed care organizations towards the transaction market is intuitive. Medicaid plans operate on slim margins even during economic upswings, absorbing high spending costs incurred by member populations that tend to experience a pronounced need for care services, specialty pharmaceuticals, and long-term care. For Medicaid plans without the funding or membership scale to absorb those spending pressures efficiently, margin compression has evolved into a near-existential challenge.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

In June of 2025, the passage of the “One Big Beautiful Bill” (H.R. 1)[1] further clouded Medicaid plans’ long-term financial outlook by, among other significant changes, adjusting federal reimbursement rules to shift a greater share of the Medicaid cost burden onto the states and tighten program eligibility. These policy changes are, according to a 2026 impact analysis by RAND, expected to reduce state Medicaid budgets by approximately $665 billion over ten years and decrease total Medicaid program enrollment by 7.6 million members over the same period.[2] H.R. 1 also curtails states’ abilities to raise Medicaid funding via provider taxes and imposes new limits on state-managed payments to provider facilities (e.g., hospitals, nursing facilities). Unsurprisingly, these funding rollbacks and restrictions have complicated the operational calculus and introduced uncertainty for state Medicaid agencies and plans alike. Many states have already responded to the new law by passing those pressures downstream through benefit restrictions, rate reductions, and enrollment controls, adding further complexity and stress for plans already under strain.

The result is a dealmaking environment primed for activity. Smaller plans seeking an orderly exit, and larger plans or investors seeking expanded geographic reach and additional membership, are increasingly in alignment. What neither side can afford to treat as secondary, however, is the regulatory framework governing these transactions—one that looks materially different today than it did ten, or even five, years ago.

State Regulators Assume a Larger Role Reviewing Health Care Transactions

Across the country, state legislatures and attorneys general are increasingly pursuing antitrust oversight of health care transactions as a policy priority, producing a wave of new pre-transaction notice requirements, expanded antitrust statutes, and more assertive enforcement postures. So far, no fewer than 21 states and Washington, DC have successfully passed legislation to prevent consolidation and boost competition within the industry. These statutes vary in their approaches; some impose new review requirements on M&A transactions, while others introduce contracting reforms. Even more states (35 as of early 2026) require parties involved in a health care transaction to notify state authorities before launching transaction proceedings.[3]

In enacting these rules, some state regulators are supplementing *federal* antitrust review authority with new state-level antitrust notification requirements.[4] For the last 50 years, the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR Act) has been the primary tool for premerger antitrust notification.[5] The HSR Act enables the federal government to identify and enforce against potentially anticompetitive deals before dealmaking is consummated. It also requires companies intending to engage in certain M&A activity to file notice with the Federal Trade Commission (FTC) and the Department of Justice (DOJ) as well as observe a 30-day mandatory waiting period before closing to permit timely government review. However, the HSR Act only covers transactions valued at or over $133.9M (adjusted annually),[6] and in the case of

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

nonprofit entities, applies to transactions that effect a change in control or transfer beneficial ownership of the target.

Certain states have adopted or are poised to adopt their own transaction review mechanisms that mirror or exceed those set by the HSR Act, meaning far more transactions and dealmaking parties may be subject to premerger antitrust review. Oregon and California have established themselves as trendsetters in this regulatory movement, establishing laws that will undoubtedly affect parties contemplating Medicaid plan transactions—and may inspire regulators in other states to pass similar requirements.

- **Oregon.** As of September 2021, Oregon House Bill 2362 requires health care entities engaged in material change transactions (including mergers, acquisitions, and affiliations involving entities with $25 million or more in average net patient revenue over the preceding three fiscal years, or transactions resulting in a net patient revenue increase of $1 million or more) to obtain prior approval from the Oregon Health Authority no less than 180 days before the closing of the transaction, based on criteria established by the Oregon Health Policy Board that assess patient benefits, health outcomes, cost impacts, and anticompetitive effects.[7] Notably, this law has persisted through legal challenges; in June 2025, a three-judge panel on the Ninth Circuit affirmed a lower court's ruling in favor of the state, dismissing a trade association's claims that the antitrust law was unconstitutionally vague and improperly delegated authority to the Oregon Health Authority.[8]
- **California.** In 2022, California took the notable step of passing SB 184, which established the Office of Health Care Affordability (OHCA) within the state's Department of Health Care Access and tasked the newly minted office with reviewing transactions (such as mergers, acquisitions, affiliations, etc.) that constitute a "material change" to a health care organization's ownership, operations, or structure for potential anticompetitive concerns.[9] A year later, the state promulgated emergency regulations that both defined 90-day notice requirements for health care organizations party to such deals (e.g., payers, health plans, hospital systems, pharmacy benefit managers) and directed OHCA to, at its discretion, conduct cost and market impact reviews (CMIR) on transactions assessed to be potentially anticompetitive.[10] Then, in 2025, Governor Gavin Newsom signed AB 1415 into law, further expanding OHCA's scope of review by expressly confirming that certain non-health care entities—including hedge funds, private equity groups, and management services organizations—would be subject to the notice regulations when engaging in health care transactions that trigger the state's "material change" review policy.[11] It should be noted that while OHCA cannot prohibit deals entirely, CMIR proceedings can, without proper planning, significantly delay transaction timelines and complicate deal closure.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

The emergence of these laws (and similar legislation in other states) makes it clear that parties intent on engaging in Medicaid plan transactions must have a clear understanding of the state laws and related review processes to which they may be subject if and when a deal proceeds.

Navigating State Regulatory Review: Context and Best Practices

Parties planning to engage in M&A should be aware that a Medicaid managed care transaction requires simultaneous navigation of at least three distinct regulatory processes, each administered by a separate body, operating on its own timeline, and exercising authority that the others cannot independently override.

The first process is the federal and state health care transaction notice and review regime, as described above. State regimes vary in their intensity; at the less demanding end, some state statutes may require an advance notice filing but confer no further authority on the reviewing agency. Others may impose a substantive review function, or—at the most demanding level—the reviewing entity may hold the power to approve a transaction, condition approval on specified changes, or prohibit the deal entirely. However, parties should keep in mind that, without proper preparation, even notice-only requirements can introduce significant timing complications for a deal.

The second process involves state insurance regulatory approvals, which proceed on an entirely independent track from the health care transaction review bodies described above. In most states, a Form A filing is required whenever a party acquires control of, merges with, or undergoes a reorganization involving a domestic insurance company, a threshold that the change-of-control mechanics of most managed care transactions will satisfy.

However, certain state agencies conduct review processes that are considerably more extensive than the Form A baseline and evaluate in more detail the capacity of the acquiring entity to comply with state insurance law and maintain required capital and the potential impacts to consumers in the state. California's Department of Managed Health Care, for example, maintains independent and comprehensive review procedures for transactions involving licensed health plans, which run concurrently with other state review processes. New York's Department of Financial Services similarly engages in parallel review of insurance transactions that may give rise to a "control relationship" (e.g., when transacting entities would gain primary influence over a state-authorized insurers' management or operational decisions). In 2022, the state even went so far as to caution insurers and investors that structuring a transaction to fall below common regulatory thresholds does not automatically avoid a "control" determination under New York Insurance Law and strongly encouraged parties to engage with the Department of Financial Services early in the deal structuring process to avoid delays or penalties.[12]

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

The third process—and the one most distinctive to Medicaid plan transactions—is securing formal consent from the state's Medicaid agency. Medicaid plans are party to extensive contracts with the state Medicaid agencies, and standard contract language prohibits a plan from transferring its contract rights without the agency's express written approval, and the conditions each state attaches to that approval differ. As with the state insurance regulatory approvals, state Medicaid agencies aim to ensure that the plans with whom they contract have the capacity to provide quality services and comply with the complex Medicaid regulatory regime. In California, for example, transfers must be effectuated through a formal written amendment signed by all three parties: the current contractor, the acquiring entity, and the agency itself. As a result, the state Medicaid agency is not simply a regulatory checkpoint but an independent principal in the transaction that imposes its own institutional priorities, minds its own decision-making calendar, and bears no obligation to align its position with outcomes reached in other review tracks.

Understanding Medicaid-Specific Transaction Hurdles

Several features of the Medicaid managed care business model introduce additional potential complications that have no real counterpart in general health care M&A.

Unlike a corporate asset that a buyer may hold indefinitely, a Medicaid managed care contract is not a permanent asset. It is a competitively procured, time-limited award, which makes the contract's remaining term and upcoming renewal schedule among the most important factors in the valuation of a Medicaid plan transaction. The transaction process itself can further complicate matters: if a deal is seen as creating organizational uncertainty at a sensitive point in the procurement cycle, it can affect the incumbent plan's standing with state officials and produce consequences that outlast the closing date. Parties should pay close attention to how key public milestones in the transaction align with the procurement calendar and plan their transaction process with that timing in mind to preserve as much value for the transaction as possible.

Market concentration presents a related challenge unique to this setting. State Medicaid agencies keep close track of how many managed care plans are operating in their programs, and they treat that number as significant and separate from any formal antitrust analysis. When a deal would reduce the number of contractors in a given market, agencies tend to scrutinize a proposed deal more closely in the interests of preserving meaningful choice for program enrollees.

Moreover, the regulatory dynamic can shift when the target is a financially distressed plan. Regulators are often more receptive to consolidating transactions when the alternative is a plan failure that leaves members without coverage or continuity of care. State governments may even step in directly, helping shape deal terms to protect access for the populations at risk. A regulator who might otherwise be skeptical of a consolidating deal may also take a more favorable view when the transaction moves

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

members to a plan with the operational and financial capacity to serve them well. Making that case proactively—and building it into regulatory submissions from the outset rather than raising it only in response to agency concerns—can make a meaningful difference in how the review unfolds.

Lastly, Medicaid managed care plans are subject to a complex regulatory operational scheme. In addition to being subject to both state and federal Medicaid laws and regulators, plans must comply with extensive obligations built into state Medicaid contracts and regularly issued informal guidance, as well as state insurance laws. Medicaid managed care plans offering dual products (which cover individuals eligible for both Medicaid and Medicare) are additionally subject to all the requirements around Medicare. The extensive nature of these overlapping requirements makes a comprehensive regulatory diligence process essential for any Medicaid plan transaction.

Implications and Best Practices for M&A-Inclined Payers

The central takeaway for organizations evaluating Medicaid plan M&A is not that the complexity makes these transactions inadvisable. The opportunity is genuine, the seller pool is growing, and the strategic logic for well-positioned acquirers is sound. However, organizations intending to take action in this environment should strongly consider:

- **Beginning regulatory planning earlier than seems necessary.** State-imposed timelines —compounded by any concurrent Medicaid agency request for proposals process—can quickly outpace a deal schedule if planning begins only after signing a letter of intent.
- **Analyzing deal structure to understand potential regulatory implications.** The choice among an equity acquisition, asset acquisition, legal entity joint venture, or contractual joint venture determines which approval regimes are triggered and what conditions may be imposed across every state in which the plan or its affiliates have material operations.
- **Engaging regulators proactively with a clear transaction narrative.** Parties that navigate review and approval processes most successfully present regulators with a clear, affirmative case from the outset, treating applicable review criteria—such as California’s OHCA factors—as organizing principles for the deal thesis.
- **Integrating antitrust and regulatory workstreams from the beginning.** Antitrust and regulatory filings may be subject to simultaneous review by overlapping sets of decision-makers; applying a coordinated approach to review workstreams will help parties avoid inconsistencies that could slow transaction approval.
- **Accounting for the procurement cycle in transaction timing.** Contract status and renewal schedule are among the most consequential variables in any Medicaid plan valuation. Aligning transaction milestones with the incumbent

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

plan's procurement calendar reduces the risk of signaling organizational instability at a critical point in the contracting process.

What the environment demands—unambiguously—is preparation: a clear-eyed understanding of the full regulatory landscape, a transaction structure and process designed with that landscape in mind, and a narrative that speaks directly to the priorities of the multiple regulatory bodies that will have a voice in the outcome.

About the Authors

Paul Mourning is co-chair of Crowell & Moring's Transactional Department and served previously as co-chair of the firm's Health Care Group. With a primary focus on the unique and complex corporate and transactional issues that face tax-exempt health care and nonprofit organizations, his clients include acute care, residential long-term care, home care, and hospice providers, as well as managed care and other health insurance organizations. He can be reached at pmourning@crowell.com.

Alice Hall-Partyka counsels payers, providers, and technology companies on a broad range of health care regulatory, corporate, and policy matters. Her practice encompasses several relevant areas of focus, including Medicaid and Medicare program requirements, mental health parity, health reform, state regulation of payers and providers, and health care fraud and abuse. She can be reached at ahallpartyka@crowell.com.

Katy Raffensperger is a trusted advisor to both public and private clients, applying her experience and insight to a full range of corporate transactions, including acquisitions, dispositions, mergers, going-private transactions, leveraged buyouts, tender offers, reorganizations, joint ventures and general corporate and complex commercial matters. Her corporate practice spans multiple industries, including health care, hospitality, sports and entertainment, technology, and manufacturing. Katy can be reached at kraffensperger@crowell.com.

Melissa Moravec regularly advises public and private companies on cross-border and U.S. domestic transactions, including mergers and acquisitions, dispositions, reorganizations, and joint ventures; her practice spans multiple industries, including health care, government contracts, manufacturing, hospitality, sports and entertainment, and technology. Melissa can be reached at mmoravec@crowell.com.

---

[1] H.R. 1, 119th Cong. (2025).

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

[2] Preethi Rao et al., *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*, RAND Corp. (Feb. 26, 2026), https://www.rand.org/pubs/research_reports/RRA4098-1.html.

[3] *From Mergers to Market Power: 2025 Legislative Recap on Health Care Consolidation*, Nat'l Conf. of State Legislatures (2025), https://www.ncsl.org/health/from-mergers-to-market-power-2025-legislative-recap-on-health-care-consolidation.

[4] *The States Step Up to the Plate: Several States Adopt and Propose New Pre-Transaction Notice Requirements and Other Antitrust Laws*, Crowell & Moring LLP (2025), https://www.crowell.com/en/insights/client-alerts/the-states-step-up-to-the-plate-several-states-adopt-and-propose-new-pre-transaction-notice-requirements-and-other-antitrust-laws.

[5] Hart-Scott-Rodino Antitrust Improvements Act of 1976, Fed. Trade Comm'n, https://www.ftc.gov/legal-library/browse/statutes/hart-scott-rodino-antitrust-improvements-act-1976 (last visited Apr. 14, 2026).

[6] *New HSR Thresholds and Filing Fees for 2026*, Fed. Trade Comm'n (Jan. 2026), https://www.ftc.gov/enforcement/competition-matters/2026/01/new-hsr-thresholds-filing-fees-2026.

[7] H.B. 2362, 81st Leg. Assemb., Reg. Sess. (Or. 2021).

[8] *Or. Ass'n of Hosps. & Health Sys. v. State of Or.*, No. 24-3770, 2025 (9th Cir. July 3, 2025) (mem.).

[9] S.B. 184, 2021-2022 Leg., Reg. Sess. (Cal. 2022).

[10] Promotion of Competitive Health Care Markets; Health Care Affordability (CMIR), Cal. Code Regs. tit. 22, §§ 97431–97442 (eff. Dec. 18, 2023).

[11] A.B. 1415, 2025-2026 Leg., Reg. Sess. (Cal. 2025).

[12] Insurance Circular Letter No. 5, N.Y. Dep't of Fin. Servs. (Apr. 19, 2022), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2022_05.

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.