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State and Federal Shifts: Key Regulatory Trends for Healthcare Investors

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Summary

Healthcare private equity faces crosswinds: aggressive legislation and regulation in many states and a largely unpredictable but possibly more permissive federal regulatory environment. Executive branch initiatives under the Trump Administration aim to dismantle regulatory barriers and promote competition. How these federal efforts will play out and impact healthcare investing is still sorting out. Deregulatory efforts, such as the delete "10-for-1"regulation executive order and large scale HHS restructuring, could impact new investments—but also inject volatility into the market.

Meanwhile, states are moving swiftly, expanding healthcare transaction notification laws and even, in the case of Massachusetts, imposing direct fraud liability on investors. Although the FTC appears more permissive under new leadership, the healthcare sector remains a top priority for enforcement.

With evolving requirements on both fronts, private equity investors must be nimble, attuned to state developments, and prepared for heightened scrutiny.

In Depth

While federal policy developments remain uncertain, state-level action continues to reshape the healthcare private equity landscape — and investors should take note of developments on both fronts. Scrutiny of healthcare private equity investment remains a priority at the state level, with additional state legislation already in 2025. Meanwhile, the federal focus, particularly at the Federal Trade Commission (FTC), may shift away from private equity, even as healthcare remains a targeted sector.

State laws scrutinizing healthcare investors continue to evolve, and some are becoming more aggressive. Massachusetts is implementing changes to its False Claims Law,[1] which imposes liability on private equity investors for failing to report violations, and at least one other state is considering similar changes. Additionally, states are increasingly adopting health care transaction notification laws, which vary significantly in their requirements and can materially impact private equity transactions.

Other brewing federal moves are likely to create both opportunities and challenges for healthcare investors as further details emerge. The Trump Administration's establishment of the Anticompetitive Regulations Task Force and the issuance of several executive orders specifically aim to dismantle regulations that hinder market competition, particularly in highly regulated sectors such as healthcare. Concurrently, other developments at the federal level, including the creation of the Department of Government Efficiency, the reorganization of the Department of Health and Human Services, and uncertain funding levels for the Medicare and Medicaid programs, are contributing to considerable upheaval and reshaping the healthcare regulatory environment. Investors who monitor these changes closely will be better positioned to respond strategically as the landscape evolves.

[1] *See* Mass. Gen. Laws Ann. 12 § 5A & 5B.

I. Federal Environment

The federal environment for healthcare private equity presents more questions than answers. The FTC may be more permissive in asserting jurisdiction and regulating dealmaking activity, but funding levels for federal health care programs, particularly Medicaid, remain unclear. The Trump Administration's broad re-organization of HHS and its deregulatory initiative are likely to impact the healthcare space, but it is too early to predict the specific impacts. The deregulatory efforts and reorganization had no clear impact on the proposed payment regulations released by the Centers for Medicare & Medicaid Services (CMS) in April.[2]

a. Antitrust

Despite the focus in the past few years on federal antitrust enforcement in the healthcare private equity arena, the FTC now is poised to permit more deals, while retaining its right to review. Previously, the FTC had targeted healthcare private equity. In 2023, the FTC sued U.S. Anesthesia Partners, Inc. (USAP) and minority private equity owner Welsh Carson for allegedly monopolizing the Texas anesthesia market through a series of acquisitions, leading to higher prices.[3] The federal district court dismissed claims against Welsh Carson because its minority, non-controlling interest was found not to constitute an *ongoing* violation of antitrust laws. The allegations against USAP were allowed to proceed. There was no allegation that the initial acquisition by Welsh Carson was a violation of antitrust laws, and the Court held Welsh Carson's minority, non-controlling ownership interest could not make it liable under Section 13(b)[4] for subsequent acquisitions by USAP that were anti-competitive: "if the FTC wants to recover for a past violation—where an entity 'has been' violating the law—it must use Section 5(b) [of the FTC Act]."[5] The related administrative suit offers some insight into the current FTC commissioners thinking on private equity.

The administrative suit alleged the initial acquisition of USAP by Welsh Carson and subsequent roll up acquisitions by USAP were in violation of Section 5 of the FTC Act and settled on January 17, 2025. Unsurprisingly, the FTC's consent order with Welsh Carson imposed restrictions on its ownership and control over USAP. The opinion of FTC Chair Lina M. Kahn in January 2025 highlights previous FTC views regarding the anticompetitive role of private equity. Chair Kahn's opinion emphasized the need for regulatory measures to prevent similar "schemes" in the future. In contrast, the concurring opinion of Commissioner Andrew N. Ferguson, now the chair of the FTC under the Trump Administration, highlights Ferguson's view that the Welsh Carson settlement was a routine enforcement action, criticizing the focus on private equity and asserting that the antitrust analysis remains consistent *regardless of investor type*. If Chairman Ferguson's statement regarding Welsh Carson reflects the FTC's current attitude to healthcare private equity (and private equity more generally), it is possible that even larger transactions with greater consolidation within a sector or subsector may receive more permissive FTC reviews. Nonetheless, Chair Ferguson has stated that "two of his top priorities" are promoting competition in "labor and healthcare markets."[6] Despite any more permissive deal environment at the FTC, Chairman Ferguson's statements suggest healthcare will continue to be a target for antitrust enforcement.

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[2] See *CMS, Newsroom, e.g.*, "Fiscal Year 2026 Skilling Nursing Facility Prospective Payment System Proposed Rule CMS 1827-P Fact Sheet" (Apr. 11, 2025), available: https://www.cms.gov/about-cms/contact/newsroom.

[3] *FTC vs. U.S. Anesthesia Partners, Inc.*, No. 4:23-CV-03560, 2024 WL 2137649 (S.D. Tex., May 14, 2024).

[4] 15 U.S.C. § 53(b).

[5] *Supra* n3 at *3 (internal citations and quotation marks omitted); 15 U.S.C. § 45(b).

[6] FTC, Press Release: "FTC Chairman Ferguson Appoints Daniel Guarnera as Director of Bureau of Competition," (Feb. 10, 2025), available: https://www.ftc.gov/news-events/news/press-releases/2025/02/ftc-chairman-ferguson-appoints-daniel-guarnera-director-bureau-competition.

b. Deregulation

The Trump Administration established the Anticompetitive Regulations Task Force under the United States Department of Justice's Antitrust Division to play a role in identifying and eliminating regulations across all economic sectors that hinder free market competition. This Task Force is part of a broader deregulatory agenda aimed at fostering a competitive and innovative market environment across various sectors, including healthcare, housing, transportation, food and agriculture, and energy.[7]

+ Executive Order 14192, signed on January 31, 2025, mandates that for each new regulation a federal agency issues, at least ten prior regulations must be identified for elimination. This "10-for-1" requirement aims to manage and control the cost of planned regulations through a rigorous regulatory budgeting process.8 The order emphasizes reducing unnecessary regulatory burdens to secure economic prosperity and national security.9

+ Executive Order 14219, signed on February 19, 2025, directs federal agencies to review existing regulations within their sole or joint jurisdiction (potentially extending to state regulations) and identify those existing regulations that, among other criteria, "impose significant costs upon private parties that are not outweighed by public benefits" or "impose undue burdens on small businesses and impede private enterprise and entrepreneurship."[10] Pursuant to OMB guidance released on April 9, 2025, agencies should identify these regulations within 60 days and must submit a report within 30 days thereafter to the OMB's Office of Information and Regulatory Affairs. In their reports to OMB, agencies must identify any regulations identified in the 60-day review that have not been targeted for repeal along with an explanation of why such regulations are not being targeted.[11]

+ Executive Order 14267, issued on April 9, 2025, mandates that agency heads, in consultation with the FTC Chair and Attorney General, identify and recommend the rescission or modification of regulations that create monopolies, create barriers to entry, limit competition (including in procurement), or "create or facilitate licensure or accreditation requirements that unduly limit competition," adding a layer of specificity to the deregulatory efforts. Within 70 days, agencies must provide a list of regulations identified by the review to the DOJ and FTC.[12]

Pursuant to the same Executive Order, the FTC issued a Request for Information (RFI) that invites public comment on federal regulations that harm competition by May 27, 2025.[13] The RFI seeks input from various stakeholders, including consumers, businesses, and academics, to identify regulations that create monopolies, limit competition, or impose unnecessary barriers to market entry.[14] On April 11, the Office of Management and Budget (OMB) issued its even broader RFI soliciting "ideas for deregulation from across the country… to identify rules to be rescinded and provide

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[7] Dep't of Justice, Antitrust Division, Anticompetitive Regulations Task Force: Webpage, available: https://www.justice.gov/atr/anticompetitive-regulations-task-force.

[8] Executive Order 14192 of Jan. 31, 2025, "Unleashing Prosperity Through Deregulation," 90 Fed. Reg. 9,065 (Feb. 6, 2025).

[9] *Id.*

[10] Executive Order 14219 of Feb. 19, 2025, "Ensuing Lawful Governance and Implementing the President's 'Department of Government Efficiency' Deregulatory Initiative," 90 Fed. Reg. 10,583 (Feb. 25, 2025).

[11] Presidential Memoranda of Apr. 9, 2025, "Directing the Repeal of Unlawful Regulations," available: https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/.

[12] *Supra* n10; Executive Order 14267 of Apr. 9, 2025, "Reducing Anti-Competitive Regulatory Barriers," 90 Fed. Reg. 15,629 (Apr. 15, 2025).

[13] OMB Notice of Apr. 11, 2025, 90 Fed. Reg. 15,481 (Apr. 11, 2025).

[14] FTC, Request for Public Comment (Apr. 14, 2025), available: https://www.ftc.gov/system/files/ftc_gov/pdf/P859900AnticompetitiveRegulationsRFI.pdf; *see also* FTC, Press Release (Apr. 14, 2025), https://www.ftc.gov/news-events/news/press-releases/2025/04/ftc-launches-public-inquiry-anti-competitive-regulations.

detailed reasons for their recission." The broader RFI from the OMB appears to seek to identify both state and federal regulations in any sector in line with its priorities and is accepting comments through May 12, 2025.[15]

The Trump Administration has emphasized that the primary goal of these deregulatory initiatives is to alleviate unnecessary regulatory burdens and foster a competitive market environment. The mechanisms employed through the Executive Orders include:

- **10-for-1 Requirement:** Agencies must identify ten existing regulations to repeal for every new regulation proposed, ensuring a net reduction in regulatory costs. [16]
- **Incremental Cost Reduction:** Agencies are directed to ensure that the total incremental cost of new regulations is significantly less than zero, promoting cost savings and efficiency. [17]
- **Public Engagement:** The FTC's RFI encourages public participation in identifying anticompetitive regulations, including specifically consumers, workers, businesses, startups, potential market entrants, investors, and academics. [18]

It is unclear how these federal deregulatory efforts will play out within healthcare sectors, but past statements from the FTC offer some guidance on which regulations the FTC may consider anticompetitive. Within healthcare, the stated focus of the deregulatory effort is on eliminating regulations that discourage low-cost, high-quality care and encourage overbilling and consolidation.[19] In the past, the FTC has submitted comments on state legislation that it considers could impact competition and consistently opposed state certificate-of-need (CON) laws.[20] CON laws require healthcare providers to obtain state approval before expanding facilities or services and may be implicated by changes of ownership or control. Further, the FTC has encouraged broader scope of practice laws for practitioners such as nurse practitioners and optometrists to encourage competition in the primary care and eye care markets, supported telehealth, and encouraged states to allow competition among accrediting or certification bodies.[21] In discussions linked to the Task Force's website, experts discussed additional potentially anti-competitive regulations including any willing provider laws, network adequacy regulations, and medical loss ratio regulations.[22] Investors may take the opportunity to submit proposals for deregulation in accordance with the RFIs. As the OMB and FTC analyze the submissions, it may become clearer if these regulations, or other areas of healthcare regulations, are likely to be impacted.

c. CMS & MA Plans

Under the Trump Administration, Medicare Advantage (MA) plans may receive more emphasis from CMS, the federal agency within HHS that provides health coverage in conjunction with States through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplaces. Medicare Advantage (MA) plans are Medicare plans offered by private insurers rather than by CMS. In its role as the nation's largest buyer of healthcare services, many of CMS's standards and practices are applicable outside Medicare because other private payors piggyback on CMS requirements. Mehmet Oz, M.D. was recently confirmed as the director of CMS on April 3, 2025.[23]

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[15] *Supra* n13.

[16] *Supra* n8.

[17] *Id.*

[18] *Supra* n14.

[19] *Supra* n5.

[20] The FTC has opposed CON laws in states including Alaska, South Carolina, Tennessee, and Virginia. *See* FTC Comments to States and Other Organizations, available: https://www.justice.gov/atr/comments-states-and-other-organizations#ala.

[21] *Id.*

[22] Dep't of Justice, Antitrust Division, Roundtable Discussion Series on Competition and Deregulations (Mar. 14, Apr. 26, and May 31, 2018), available: https://www.justice.gov/media/981866/dl?inline.

[23] PN12-34 (Apr. 3, 2025), https://www.congress.gov/nomination/119th-congress/12/34.

Dr. Oz has consistently expressed support for expanding access to MA plans,[24] and during his confirmation hearing he reiterated that support. However, Dr. Oz also committed to taking steps to increase MA plan transparency, accountability, network adequacy and access. Further, he emphasized the need to address fraud, waste and abuse in the MA program and acknowledged concerns around delays with prior authorizations.[25] Dr. Oz's previous support for MA programs suggests MA programs' use over traditional Medicare will continue to grow, though the confirmation hearings highlighted that there will continue to be pressure to scrutinize MA plans for fraud and abuse concerns, cost savings, and patients experience.

MA plans have seen an unexpectedly large reimbursement increase under the Trump Administration. The rate increase for 2026 is projected to be 5.06%, resulting in over $25 billion in additional payments to MA plans, as announced by CMS.[26] This is a significant increase over the Biden administration's proposed 4.33% increase, or over $21 billion.[27] While MA plans have celebrated the increase, the increase may be influenced by technical factors (*e.g.*, the Effective Growth Rate and adjustments in star ratings and risk models) more than Trump Administration priorities.[28] While the Administration's plans for traditional Medicare are less clear, MA plans (serving more than half of Medicare enrollees) seem likely to receive more focus.

d. FY 2026 Federal Budget

The Federal Budget, of course, remains an open question. While the White House's FY 2026 Budget is expected to be released in mid-May, the FY 2025 Budget is still winding its way through Congress's reconciliation process, even though we are over halfway through FY 25. The most recent developments in the widely reported budget battle involved the House of Representative approving a FY 2025 budget on February 25, 2025, and the U.S. Senate approving an amended version on April 5.[29] The House Budget included instructions to reduce the federal deficit by at least $880 billion over 10 years, which the Congressional Budget Office confirmed could not be accomplished without making cuts to Medicare and/or Medicaid.[30] The Senate Budget includes instructions to *protect* Medicaid funding. While it is not clear how the eventual reconciliation bill will resolve these conflicting instructions, the direction of any Medicaid funding moves seems clear.[31,32]

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[24] *See, e.g.*, Mehmet Oz and George Halvorson, "Medicare Advantage For All Can Save Our Healthcare System," Forbes (Jun. 11, 2020), available: https://www.forbes.com/sites/steveforbes/2020/06/11/medicare-advantage-for-all-can-save-our-health-care-system/.

[25] Responses to Questions From the Record To Mehmet Oz (Mar. 14, 2025), available: https://www.finance.senate.gov/hearings/hearing-to-consider-the-nomination-of-mehmet-oz-of-pennsylvania-to-be-administrator-of-the-centers-for-medicare-and-medicaid-services-vice-chiquita-brooks-lasure-resigned.

[26] CMS, 2026 Medicare Advantage and Part D Advance Notice Fact Sheet (Apr. 7, 2025), https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement.

[27] CMS, 2026 Medicare Advantage and Part D Advance Notice Fact Sheet (Jan. 10, 2025), https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-advance-notice-fact-sheet.

[28] *Supra* n26.

[29] H. Con. Res. 14 (engrossed Feb. 25, 2025), available: https://www.congress.gov/bill/119th-congress/house-concurrent-resolution/14/all-actions.

[30] Mar. 5, 2025 Letter from Congressional Budget Office to Budget and Energy & Commerce Committees, available: https://www.cbo.gov/system/files/2025-03/61235-Boyle-Pallone.pdf.

[31] Concurrent Resolution on the Budget for FY 2025 (April 10, 2025), available: https://www.congress.gov/bill/119th-congress/house-concurrent-resolution/14/text.

[32] Further confusing intentions on federal healthcare spending, an OMB Memo temporarily paused agency grant, loan, and financial assistance programs. OMB, M-25-13 (Jan. 27, 2025), available: https://www.whitehouse.gov/wp-content/uploads/2025/03/M-25-13-Temporary-Pause-to-Review-Agency-Grant-Loan-and-Other-Financial-Assistance-Programs.pdf. While the memo was quickly rescinded, and did not pause "assistance received directly by individuals" (*e.g.,* SNAP, Medicare), some Medicaid program funding may have been impacted. *See, e.g.,* Press Release, Office of Chuck Schumer (Feb. 6, 2025), available: https://www.schumer.senate.gov/newsroom/press-releases/schumer-demands-answers-new-yorks-medicaid-portal-just-temporarily-shut-down-again-following-trumps-funding-freeze-fiasco-last-week-senator-calls-for-full-investigation-to-protect-nearly-7-million-new-yorkers-from-health-care-disruptions. The memorandum was rescinded by M-25-14 on January 29, 2025 (OMB, M-

e. Department of Health and Human Services

The U.S. Department of Health and Human Services (HHS) is undergoing a significant transformation as part of the "Make America Healthy Again" initiative, aimed at enhancing efficiency and addressing chronic disease in America.[33] This restructuring is in line with President Trump's Executive Order on workforce optimization and involves a comprehensive overhaul of the department's operations.[34] While less directly relevant for the environment impacting healthcare transactions, the structural changes at HHS impact the environment in which many healthcare providers operate generally and could, for example, slow the review of transactions requiring CMS approval (*e.g.*, Medicare changes of ownership).

A key component of this transformation is the significant reduction of the HHS workforce from 82,000 to 62,000 full-time employees. This reduction is being achieved through voluntary resignation programs with further reductions in force, targeting duplicative and redundant functions within the department.[35] The restructuring also involves the consolidation of twenty-eight divisions into fifteen, centralizing core functions such as Human Resources, Information Technology, and Procurement to eliminate inefficiencies.[36] The reductions in force may lengthen deal timelines when involving "changes of ownership" or enrollments, as these require approval of CMS personnel.

This is not the only change shaking things up at HHS. A newly created Administration for a Healthy America (AHA) will consolidate several agencies, including the Office of the Assistant Secretary for Health, Health Resources and Services Administration, and others, to better coordinate health resources for low-income Americans. The AHA will focus on areas such as Primary Care, Maternal and Child Health, and Mental Health.[37] Additionally, the restructuring seeks to refocus the Centers for Disease Control and Prevention (CDC) on outbreak response and preparedness, with the Administration for Strategic Preparedness and Response being transferred to the CDC for a net loss of 1,400 personnel.[38] The creation of a new Assistant Secretary for Enforcement is intended to enhance oversight and combat waste, fraud, and abuse within federal health programs including oversight of the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeals (OMHA), and Office for Civil Rights (OCR).[39] The upheaval at HHS caused by the reorganization and workforce optimization could prove a challenging environment to implement the Administration's deregulatory agenda as well as other initiatives at HHS.

25-14 (Jan. 29, 2025), available: https://www.whitehouse.gov/wp-content/uploads/2025/03/M-25-14-Rescission-of-M-25-13.pdf.), but the Administration later emphasized that while the OMB memo had been rescinded, its executive orders on federal funding remain in full force and effect. *See* Press Secretary Karoline Leavitt, Jan. 29, 2025, X Post ("This is NOT a rescission of the federal funding freeze. It is simply a rescission of the OMB memo. Why? To end any confusion created by the court's injunction. The President's EO's on federal funding remain in full force and effect, and will be rigorously implemented."), available: https://x.com/PressSec/status/1884672871944901034.

[33] The Make America Healthy Again (MAHA) Commission was established by Executive Order 14212 on Feb. 13, 2025. Pursuant to the order, the MAHA Commission is to be chaired by the Secretary of HHS but includes other agencies such as the Department of Agriculture, Department of Housing and Urban Development, Department of Education, Department of Veterans Affairs, the Environmental Protection Agency, and the Food and Drug Administration. *See* Executive Order 14212 of Feb. 13, 2025, 90 Fed. Reg. 9,833 (Feb. 19, 2025); *see also* Dep't of Health and Hum. Svcs., Press Release: "HHS Announces Transformation to MAHA" (Mar. 27, 2025), available: https://www.hhs.gov/press-room/hhs-restructuring-doge.html.

[34] Dep't of Health and Hum. Svcs., "Fact Sheet: HHS' Transformation to Make America Healthy Again," available: https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html; *see also* Presidential Action of Feb. 13, 2025: "Establishing the President's Make America Healthy Again Commission," available: https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.

[35] *Id.*; *supra* n33.

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

f. Department of Government Efficiency

The Trump Administration established a Department of Government Efficiency (DOGE) to advance "the President's 18-month agenda" as a temporary organization that will terminate on July 4, 2026.[40] Each federal agency is required to establish a DOGE team, typically consisting of a team lead, an engineer, a human resources specialist, and an attorney, to coordinate with DOGE and advise on implementing its agenda.[41]

The Executive Order does not clearly define the purposes or remit of DOGE. Rather, DOGE is tasked with implementing a "Software Modernization Initiative" to improve federal software and IT systems, promoting interoperability among agency networks, but the order contains few other specific directives.[42] All agency heads must provide, to the maximum extent allowed by law, "full and prompt access to all unclassified agency records, software systems, and IT systems." The DOGE initiative also involves accessing unclassified agency records and systems, with a focus on IT and HR management, procurement, real property, and agency operations.[43]As DOGE's changes are ongoing, it is contributing to the uncertainty around federal policy towards healthcare private equity.

II. State Environment

While the regulatory and legislative environment for private equity transactions is unique in each state, many states are moving in similar ways to address policy concerns about private healthcare investment. More states are adopting health care transaction notification laws that target non-provider investors such as private equity funds. Massachusetts has extended liability for certain healthcare violations to investors who knew about violative conduct but did not report, and Connecticut is considering a similar change to its fraud and abuse law. With these new requirements and added liability exposure, states are increasingly asking investors to justify their investments on public policy grounds.

a. Health Care Transaction Notification Laws

States are increasingly adopting health care transaction notification laws.[44] Healthcare investors are aware of the change of ownership (CHOW) filing requirements that often accompany transactions involving licensed healthcare entities. While CHOW filings assist regulators in oversight of licensed or enrolled entities, the newer health care transaction notification laws focus on state-specific policy concerns beyond licensure compliance. Health care transaction notification laws are often explicitly attempting to scrutinize private equity investment in the healthcare sector, particularly healthcare providers.

The emerging requirements vary by state. Some states, such as New Mexico and Oregon, require written approval from governmental authorities before a transaction may close and allow conditions on future operations to be imposed on reviewed transactions. Others, such as Illinois and Indiana, primarily require advance notice without explicit approval or conditions. Information to be submitted includes details about the parties involved, the nature of the transaction, and its anticipated impact on healthcare costs, access, quality, or competition. Covered transactions range from providers (*e.g.*, hospitals and physician practices) to management services organizations and health insurers.

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[40] Executive Order of Jan. 20, 2025 ("DOGE EO"), "Establishing and Implementing the President's 'Department of Government Efficiency, " 90 Fed. Reg. 9,669 (Feb. 14, 2025); *and* Congressional Research Service, Department of Government Efficiency Executive Order: Early Implementation (Feb. 6, 2025), available: https://www.congress.gov/crs-product/IN12493.

[41] DOGE EO.

[42] *Id.*

[43] *Id.*

[44] Some states have requirements, which predate the current trend, to notify the medical board of transactions involving registered physician organizations. *See, e.g.,* N.C. Med. Bd., Handbook for Managing Professional Corporations, Professional Associations and Professional Limited Liability Companies," available: https://www.ncmedboard.org/images/uploads/other_pdfs/CorporationsHandbook_06122023.pdf.

State	Pre-Transaction Filing Deadline	Entities Subject to Requirement
California[45] (2023)	90 days	Payors, providers, and fully integrated delivery systems
Connecticut[46] (2014)	30 days for affiliations of hospitals and health systems, or when filed with FTC.	Hospitals, health systems, healthcare providers, and group practices
Illinois[47] (2024)	30 days	Healthcare facilities and provider organizations
Indiana[48] (2024)	90 days	Health care entities, including insurers and any business that provides diagnostic, medical, surgical, dental, or rehabilitative care.
Massachusetts[49] (2025)	60 days	Providers or provider organizations
Minnesota[50] (2023)	30 days or 60 days (depending on revenue)	Health care entities with over $80M in revenue or between $10M and $80M
Nevada[51] (2021)	60 days[52]	Hospitals and MSOs managing hospitals
New Mexico[53] (2025)	At least 120 days	Hospitals, health care provider organizations, and independent health care practices
New York[54] (2023)	30 days	Health care entities, including physician practices, management services organizations, and health care facilities, organizations, or plans
Oregon[55] (2022)	180 days	Health care entities, including individual professionals, physician groups, insurance plans, hospitals, and any other entity that primarily provides health items or services
Washington[56] (2020)	60 days	Hospitals, hospital systems, and provider organizations

[45] *See* Cal. Health & Saf. Code § 127500 *et seq.*; 22 CCR 97431 *et seq.*

[46] *See* Conn. Gen. Stat. Ann. § 19a-486i.

[47] *See* 740 Ill. Comp. Stat. 10/7.2a.

[48] *See* Ind. Code §§ 25-1-8.5-1 through 25-1-8.5-4.

[49] *See* Mass. Gen. Laws Ch. 6D § 13; 958 CMR 7.00.

[50] *See* Minn. Stat. § 145D.01 & 145D.02.

[51] *See* Nev. Rev. Stat. § 598A.290 *et seq.*; *and* Nev. Rev. Stat. § 439A.126.

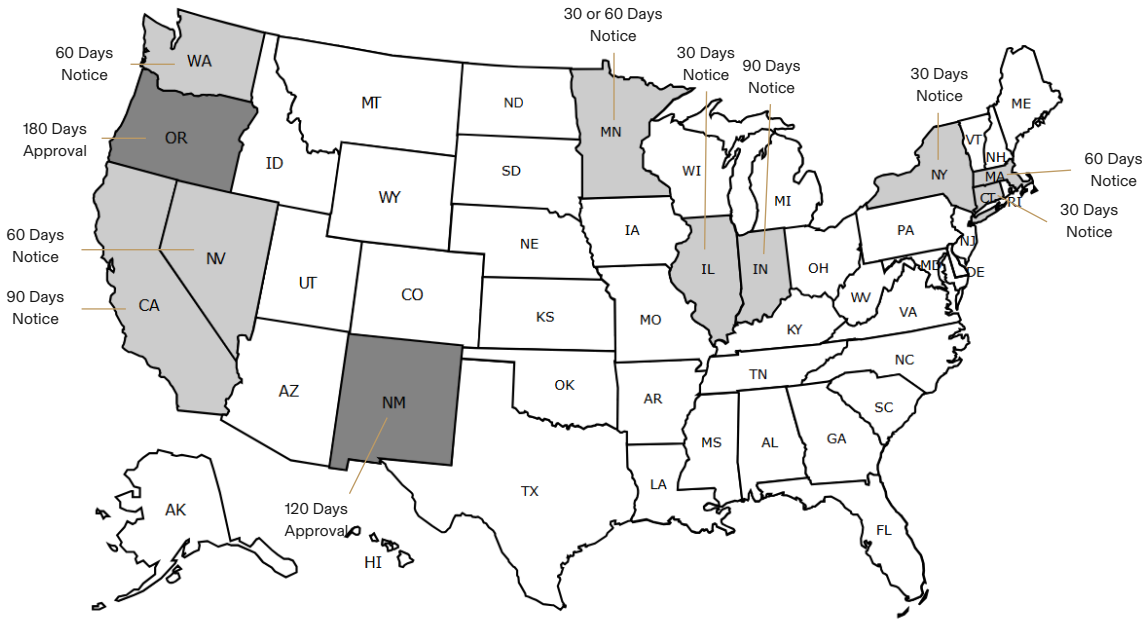
[52] Some states require more than one filing. In states with more than one filing deadline, the longer deadline is listed.

[53] *See* 2025 New Mexico Laws Ch. 50 (H.B. 586) (effective July 1, 2025).

[54] *See* N.Y. Pub. Health Law § 4550 *et seq.*

[55] *See* Or. Rev. Stat. § 415.500 *et seq.*; Or. Admin. R. 409-070-0000 through -0085.

[56] *See* Wash. Rev. Code § 19.390.



The importance of these laws for a particular transaction hinge on the finer points. Some requirements apply only to specific provider types or those exceeding certain revenue thresholds, some states require the reporting of significantly more information (including on a post-closing basis) than other states, and some states require a review of the transaction (while others only authorize a review). The requirements are also in flux. At least one faces a legal challenge and amendments to several are pending.[57] Further, additional states are considering similar laws.[58]

Oregon has one of the strictest transaction notification laws, requiring prior approval of "material change transactions" of certain healthcare entities. An Oregon "material change transaction" must have significant revenue: one party involved must average at least $25 million in revenue in the preceding three fiscal years and the other party must have averaged $10 million in the preceding three fiscal years or be projected to have $10 million in revenue in its first full year.[59] Health care entities subject to review include individual health professionals, hospitals, carriers offering health benefit plans, Medicare Advantage plans, coordinated care organizations, and other entities primarily providing health care services, excluding long-term care facilities and certain licensed facilities. The Oregon Health Authority (OHA) may condition approvals on certain operational requirements to ensure transactions align with public interest goals, such as maintaining access to affordable health care (*e.g.*, a proposed acquisition of substantially all the non-clinical

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[57] *See, e.g., Or. Ass'n of Hospitals and Health Systems v. State of Oregon, et al.*, No. 24-3770 (9th Cir., pending as of April 25, 2025); *and* N.Y. FY 2026 Executive Budget, available: https://www.budget.ny.gov/pubs/archive/fy26/ex/fy26bills.html (amending N.Y. Pub. Health Law § 4550 *et seq.* (New York's Material Transaction Law)).

[58] *See, e.g.,* Tex. H.B. 2747, available: https://capitol.texas.gov/tlodocs/89R/billtext/pdf/HB02747I.pdf/.

[59] However, Oregon "material change transactions" do not include: "(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs. (B) A medical services contract or an extension of a medical services contract. (C) An affiliation that: (i) Does not impact the corporate leadership, governance or control of an entity; and (ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386. (D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity: (i) Maintains responsibility, oversight and control over the patient care and services; and (ii) Bills and receives reimbursement for the patient care and services. (E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b." Or. Rev. Stat. Ann. § 415.500.

assets of a physician practice and ambulatory surgical center by a PE-backed MSO was approved with conditions including that the MSO could not enter into employment agreements with any clinical personnel and must continue to serve Medicare patients).[60] Required submissions include detailed transaction information, financial statements, the terms of the agreement, and definitive documentation of the transaction.[61] Post-closing, entities must notify the OHA of transaction completion and comply with follow-up analyses conducted one, two, and five years after the transaction to assess compliance and impact.

Parties to transactions in Indiana, for example, have less onerous requirements.[62] Indiana requires notice be provided to the Indiana Attorney General (AG) 90 days in advance of any mergers, acquisitions, or asset sales of health care entities, which include private equity partnerships that invest in, or any business that provides, diagnostic, medical, surgical, dental treatment, or rehabilitative care.[63] However, the requirement applies only when the combined entities and holdings exceed $10 million. While Indiana AG has separate antitrust enforcement authorities, the Indiana statute provides the AG with authority to delay transactions beyond the 90-day notice period, does not require the Indiana Attorney General to produce a report, and the information reporting requirements are minimal.

b. Fraud, Waste and Abuse Liability

An amendment to the Massachusetts False Claims Act (MFCA) creates new direct risk for healthcare investors. Like its Federal and many state counterparts, the MFCA imposes liability on any individual or entity who submits false claims to Massachusetts government employees/agents or to be paid with Massachusetts state funds (including Medicaid).[64] Since January 8, 2025, however, certain investors (including interests held by private equity funds or private equity professionals)[65] in an entity that violates the MFCA and who "know" about the violation may be subject to liability unless the investor reports the violation to the state within 60 days.[66] The applicable Massachusetts definition of "know" includes actual knowledge, deliberate ignorance, and reckless disregard of the truth.[67] This duty to report could subject an investor to MFCA liability for a (reckless or deliberately ignorant) failure during diligence to "identify" MFCA violations, though future regulations, case law, or guidance may narrow the reach of the MFCA amendments.

As of April 2025, the Connecticut General Assembly is considering similar changes to the Connecticut False Claims Act.[68]

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[60] *See* In re Proposed Material Change Transaction of Agility Podiatry MSO, KeiperSpine, and Spine Surgery Center of Eugene, Trans. No. 017 (Oregon Health Authority, Mar. 18, 2024), available: https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/017-Agility-Keiper-order.pdf.

[61] Oregon regulations require definitive documentation to be submitted at least 15 days before the close of the transaction, and the review period may be extended if the definitive documentation materially differs from a term sheet submitted with an original notice. O.A.R. 409-070-0045(5).

[62] Indiana is considering additional reporting requirements for health care entities. *See* I.N. H.B. 1666, available: https://iga.in.gov/legislative/2025/bills/house/1666/details.

[63] Ind. Code 25-1-8.5-4(a).

[64] Mass. Gen. Laws Ann. 12 § 5B.

[65] Investors, or those with an "ownership or investment interest," include "(1) direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of an entity; (2) interest held by an investor or group of investors who engages in the raising or returning of capital and who invests, develops or disposes of specified assets; or (3) interest held by a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds." *See* Mass. Gen. Laws Ann. 12 § 5A.

[66] 2024 Mass. Legis. Serv. Ch. 343 (H.B. 5159) (Jan. 8, 2025).

[67] *Id.*

[68] File. No. 691, "An Act Expanding Liability Under The False Claims Act For Entities With An Ownership Interest And Prohibiting The Licensing Of Hospitals With Certain Lease Back Arrangements," available: https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB07224&which_year=2025.

III. Conclusion

The first few months of the Trump Administration have clearly brought tremendous change in many areas of the economy and promises of transformative change to many aspects of the healthcare sector. But the details of the coming changes for healthcare investment landscape, particularly the deregulatory efforts and structural changes at HHS, have not been made publicly available and are likely to take some months to implement. Thus, the federal environment is marked by uncertainty, with potential substantive changes in the FTC's approach to reviewing transactions. Aggregate federal healthcare spending levels, particularly for state Medicaid programs, seem unlikely to increase, but the tumult in Washington makes predictions at the Federal level difficult. States, meanwhile, are pushing ahead with their agendas. Healthcare investors can expect more states to adopt or strengthen healthcare transaction notification laws, but it is not yet clear whether more States will follow Massachusetts in imposing liability on healthcare investors.

The regulatory environment for healthcare private equity is becoming increasingly complex, with significant developments at both federal and state levels. The Trump Administration's deregulatory initiatives may create new opportunities in the healthcare sector if regulations are rescinded that favorably change market dynamics, but those opportunities may look different across the country. As states impose additional hurdles on health care transactions and subject healthcare investors to additional risk, the individual state regulatory environment will be an increasingly important factor in investment decisions.

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