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Healthcare Alert

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CMS hospice and home health agency moratorium: Impact on M&A and ownership changes

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CMS's new nationwide moratorium on hospice and home health agency enrollments is an immediate M&A disruptor. Buyers, sellers, and sponsors must reassess transaction strategy now.



What's the impact?

- For the next six months, and potentially longer, any deal structure requiring a new Medicare enrollment number (or triggering a new Medicare provider agreement) is effectively off the table.
- Only change of information (COI)-eligible equity deals, carefully calibrated against the 36-month rule, can preserve Medicare billing without interruption.
- Expect delayed deal closings, renegotiated terms and structures as buyers model moratorium scenarios extending past November 2026.

On May 13, 2026, the Centers for Medicare & Medicaid Services (CMS) imposed a six-month nationwide temporary moratorium on Medicare enrollment for new Home Health Agencies (HHAs) and hospice providers, issued through two companion *Federal Register* notices (CMS-

6101-N for HHAs and CMS-6102-N for hospices) and announced in coordination with Vice President JD Vance's Anti-Fraud Task Force. This sweeping action, along with the recent DME POS moratorium, represents the most significant program-integrity interventions in the post-acute care sector in recent years and are marked departures from CMS's historical practice of imposing geographically targeted moratoria (e.g., the 2013 HHA moratoria limited to specific counties in Florida and Illinois). The HHA/hospice moratorium directly blocks new provider enrollments and Change in Majority Ownership (CIMO) transactions that would otherwise require a new initial enrollment application under the so-called "36-month rule" (42 C.F.R. § 424.550(b)).

The moratorium applies across the entire country and US territories and is initially set to run through approximately November 13, 2026, subject to potential six-month extensions that would be announced by *Federal Register* notice. CMS may lift the moratorium earlier under § 424.570(d) if (i) the president declares an area disaster under the Stafford Act, (ii) the circumstances warranting the moratorium have abated or CMS has implemented adequate program safeguards, (iii) the secretary declares a public health emergency, or (iv) the secretary otherwise determines the moratorium is no longer needed. Even after the moratorium is lifted, HHAs and hospices that apply to enroll within six months of the lift date will be assigned to the "high" screening level under 42 C.F.R. §§ 424.518(c)(3)(iii) and 455.450(e)(2), triggering site visits and fingerprint-based criminal background checks of 5% or greater owners. Existing enrolled HHAs and hospice providers may continue billing Medicare without interruption, provided they do not undergo a CIMO that triggers a new enrollment. Enrollment applications received by Medicare contractors before May 13, 2026, are grandfathered under § 424.570(a)(1)(iv); applications submitted on or after that date will be denied.

The moratorium sits alongside a broader CMS program-integrity package announced the same day, including nationwide hospice site visits, heightened oversight of newly enrolled hospices in higher risk states (Arizona, California, Georgia, Nevada, Ohio, and Texas), enhanced HHA enrollment screening with site verification and fingerprint-based background checks, an expanded pre- and post-claim review demonstration for HHAs in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas, and a new public hospice scoring system. Stakeholders should also note that this action follows CMS's February 27, 2026, nationwide moratorium on [Medicare enrollment of certain DMEPOS medical supply companies](#). These actions signal a sustained appetite for nationwide enrollment freezes.

Background about CHOW/CIMO Process for HHA and hospice providers

An HHA or hospice provider enrolls with Medicare via Form CMS-855A and receives a CMS Certification Number (CCN) along with a Medicare provider agreement. Unlike DMEPOS suppliers, HHAs and hospices are also subject to the provider agreement transfer rules at 42

C.F.R. § 489.18, but the 36-month rule at 42 C.F.R. § 424.550(b) governs when a change of ownership requires a new initial enrollment.

Two primary pathways exist:

- / **Change of information (COI)**—Minor or non-majority ownership changes, indirect ownership shifts at the parent level, or stock purchases that do not alter the provider’s legal entity or result in a CIMO within the 36-month window are reported as updates to the existing enrollment application (855A). The provider continues under its current CCN and provider agreement with no new survey or accreditation required.
- / **Change in majority ownership (CIMO) triggering new initial enrollment**—Under the 36-month rule (42 C.F.R. § 424.550(b)), if an individual or organization acquires more than 50% direct ownership interest (via asset sale, stock transfer, merger, consolidation, or the cumulative effect of multiple transactions) within 36 months after the provider’s initial enrollment or its most recent CIMO, the existing enrollment and provider agreement terminate. The buyer must submit a full new initial 855A application, undergo a fresh state survey or accreditation, meet all Conditions of Participation, and receive a new CCN. Medicare billing privileges do not transfer automatically.

Exceptions permitting continuation without new enrollment include death of an owner, pure internal corporate restructurings with identical ultimate owners, or certain other limited circumstances (e.g., full cost report history in some cases).

Transaction structuring

ASSET PURCHASE AGREEMENTS (APAS)

In a classic asset deal, the buyer (or its new subsidiary) acquires the operating assets, contracts, and other assets of the HHA or hospice business divesting from the seller’s legal entity that holds the Medicare provider agreement. These structures are legally preferable because the buyer avoids successor liability for the seller’s operation. However, this almost always requires the buyer to enroll as a new provider (or triggers a CIMO) because:

- / A new legal entity is typically formed to receive the assets.
- / The transfer of the provider business itself is treated as requiring a new initial enrollment or new practice location.
- / The transaction inherently triggers the CIMO rule if >50% ownership interest in the “business” changes hands within the 36-month window.

Result under the moratorium

The buyer cannot obtain Medicare billing privileges (or a new provider agreement) for the acquired assets during the moratorium period. Deals structured as pure asset purchases are effectively frozen unless the buyer can operate without Medicare revenue or delay closing until the moratorium lifts. Parties may also consider “interim” transaction structures that attempt to match the economics of the transaction, but is carefully calibrated to avoid a CIMO.

STOCK PURCHASE AGREEMENTS (SPAS)/EQUITY PURCHASES

In a stock (or membership-interest) deal, the buyer acquires shares or membership interests in the existing legal entity that already holds the Medicare enrollment, provider agreement, and contracts with third-party payors. Because the provider’s legal entity, FEIN, CCN, and provider agreement remain unchanged:

- / The transaction is generally reportable as a Change of Information (COI) rather than a new initial enrollment (provided it does not trigger the 36-month CIMO rule).
- / The existing accreditation/survey, provider agreement, and CCN continue uninterrupted.

Critical caveat

If the stock purchase results in a >50% direct ownership change (or the cumulative effect in any rolling 36-month period exceeds 50%) within 36 months after the last enrollment or CIMO, the CIMO rule is still triggered, requiring a new initial enrollment application, fresh survey/accreditation, and new CCN—which the moratorium blocks.

Result

A 100% stock purchase of an HHA or hospice, especially those whose last enrollment or CIMO was more than 36 months ago, can often close and continue Medicare operations without new enrollment. Partial acquisitions below the 50% threshold (on a direct-ownership, rolling 36-month basis) may also proceed as COI updates.

It should be noted, however, that in a stock or equity purchase of an HHA or hospice provider, the buyer acquires the existing legal entity holding the Medicare CCN and provider agreement, automatically assuming all liabilities (known, unknown, and contingent)—with no clean break from the seller’s past conduct. This may expose the buyer to historical Medicare or other third-party payor overpayments, False Claims Act exposure, regulatory enforcement actions, employee claims, tax liabilities, and other hidden risks that may surface years later. Unlike a well structured asset purchase, which allows selective asset assumption and express disclaimer of most liabilities, stock deals transfer the full historical burden.

Key impact on healthcare transactions

Although the CMS moratorium is designated as a temporary enrollment freeze, it marks a significant escalation in CMS's program-integrity posture toward hospice and home health providers and is part of a coordinated anti-fraud agenda. Deal strategies involving HHAs or hospices should be reassessed with heightened scrutiny, prioritizing structures that preserve existing Medicare provider agreements and conducting detailed ownership history analyses (including the 36-month clock) to avoid inadvertent CIMO triggers. The scarcity of newly enrolled providers is also likely to drive up valuations of existing HHAs and hospices with clean enrollment histories, intensifying competition for acquisition targets. In a moratorium environment, buyers may be forced to accept heightened successor-liability risk to preserve uninterrupted Medicare billing privileges, making rigorous due diligence, larger escrows, and robust indemnification essential.

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