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Mergers and Acquisitions in the Healthcare Industry: Medicare and Medicaid Change of Ownership Considerations

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The Medicare program is a health insurance program administered by the federal government benefitting the elderly and disabled, and the Medicaid program is a health insurance program administered by the states benefitting low-income individuals. Together, the Medicare and Medicaid programs expend over $1.1 billion annually—about one third of the entire U.S. national health expenditure—for healthcare items and services furnished to their beneficiaries. Given the dollars involved, it is no wonder that many providers and suppliers are highly dependent upon payments from these governmental programs. Yet, participation in these programs exposes providers and suppliers to significant risks of recoupment of payments, penalties, and false claims act liability if the regulatory requirements of these programs are not followed. Therefore, when a healthcare provider or supplier is involved in an M&A transaction, especially important considerations revolve around the provider's or supplier's participation in the Medicare and Medicaid programs.

This practice note will focus primarily on the "change of ownership" considerations for providers that furnish services reimbursed under Medicare Part A, such as inpatient care furnished by hospitals, care in skilled nursing facilities, hospice care, and home health services. Similar considerations also apply to entities providing services reimbursed under Medicare Part B, such as hospitals furnishing outpatient services, ambulatory surgical centers, durable medical equipment companies, clinical laboratories, and outpatient rehabilitation clinics.

The Classification of Transactions under Medicare Rules

The implications of an M&A transaction on a Medicare provider depend, in the first instance, upon how the transaction is classified under Medicare rules. The structure of a transaction will determine its classification for Medicare purposes. The classification also has implications on due diligence, representations and warranties, indemnities, and other provisions in the purchase agreement, and the timing for completion of the transaction.

How M&A Transactions Are Classified under Medicare Rules

In general, depending on the structure of the transaction and other factors, an M&A transaction can be classified as any of the following:

- A change of ownership transaction
- A transaction involving a "change of information"
- A transaction requiring a new Medicare enrollment

The classification of an M&A transaction determines such things as the timing and process for regulatory notices and approvals, whether there will be any interruption in Medicare billing and payment for the provider's services, and whether successor liability for pre-closing overpayments and penalties will attach.

Given the implications on the classification of an M&A transaction, an important consideration in deciding how to structure a transaction is often how the transaction will be classified for Medicare purposes.

Change of Ownership Transactions

In general, under Medicare regulations (42 C.F.R. § 489.18) a transaction in which a new legal entity becomes the owner and operator of a Medicare-enrolled provider constitutes a change of ownership. Change of ownership is a term of art in the Medicare program, and is sometimes abbreviated as "CHOW." The following are among the types of transactions that are classified as changes of ownership:

- **Merger or consolidation into another corporation.** Medicare regulations specifically provide that the merger of a corporation that directly owns and operates a provider into another corporation is a change of ownership. Similarly, the consolidation of two or more corporations, at least one of which directly owns and operates a provider, resulting in the creation of a new corporation, is also regarded as a change of ownership. In contrast, as discussed below under Change of Information Transactions, the merger of another corporation into a provider corporation, or the sale of stock of a corporation that owns a provider, would not be a change of ownership, but rather could involve a change of information.

- **Removal, addition, or substitution of partner.** Under Medicare regulations, the removal, addition, or substitution of a partner in a partnership constitutes a change of ownership because, under state law, such an event has often been regarded as involving the dissolution and reconstitution of the partnership. However, if state law permits the continuation of the partnership notwithstanding any such event through a provision in the partnership agreement, the transaction will not be regarded as a change of ownership, but rather will involve a change of information.

- **Asset sale.** Medicare regulations do not specifically address asset sale transactions, except in the context of a sale by a sole proprietor of a provider. Nevertheless, when an entity (such as a corporation, limited liability company, or partnership) that owns and operates a provider transfers its assets to another entity that will thereafter own and operate the provider, a change of ownership likewise occurs.

- **Facility lease.** The lease of all or part of a provider facility to another entity that will subsequently operate the provider constitutes a change of ownership under Medicare regulations. However, a sale-leaseback transaction, where the seller continues to be responsible for operating the provider facility, will normally not involve a change of ownership.

The transactions described above are referred to in Medicare guidance as "standard" CHOWs. The guidance acknowledges that a standard CHOW is the most frequently encountered change of ownership transaction. However, the guidance also refers to other types of change of ownership transactions, termed "acquisition/merger" and "consolidation" CHOWs. These relate to unusual scenarios and are not discussed in this practice note.

Because, as described below in "Consequences of a Transaction Constituting Change of Ownership" under Change of Ownership Transactions, a transaction that constitutes a change of ownership has some disadvantages when compared with a transaction that involves a change of information, owners, and buyers of Medicare providers often structure their businesses in a manner that facilitates the classification of a future transaction as a change of information rather than a change of ownership. For example, partnerships owning Medicare providers often include provisions ensuring the continuity of the partnership where a partner is removed, added, or substituted. Even more common, entities owning multiple provider facilities typically own each provider facility through a special purpose subsidiary so that an individual facility can be sold through the sale of stock, which is classified as a change of information, rather than the sale of assets, which is classified as a change of ownership.

A common misconception is that a change in the taxpayer identification number associated with the provider defines the occurrence of a change of ownership. Guidance from the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, makes clear that this is not the case, however. A provider's TIN can change without triggering a change of ownership, and a change of ownership can take place even if the provider's TIN does not change.

Special Rules for Home Health Agencies

In an effort to combat perceived abuses, CMS has established special rules for certain transactions involving Medicare-certified home health agencies. The so-called "36-month rule" within 42 C.F.R. § 424.550(b) applies to transactions where there is a "change in majority ownership" of a home health agency by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the home health agency's initial enrollment in Medicare or within 36 months after the home health agency's most recent change in majority ownership. For such transactions, the provider agreement and Medicare billing privileges "do not convey to the new owner"; instead, the home health agency must seek new enrollment in the Medicare program and obtain a state survey or an accreditation from an approved organization.

There are four exceptions to the 36-month rule. It does not apply if:

1. The home health agency has submitted two consecutive years of full cost reports.
2. The home health agency's parent company is undergoing an internal corporate restructuring.
3. The owners are changing their business structure but the owners remain the same.
4. An individual owner of a home health agency dies.

The 36-month rule applies only to transactions involving a change in direct majority ownership of the home health agency. It does not apply where there is a change in ownership of an entity that indirectly owns the home health agency. Therefore, in addition to considering whether it may be possible to structure an M&A transaction to avoid the impact of the 36-hour rule, a buyer may also want to consider how to structure its business in order to avoid the potential application of the 36-month rule on future sale transactions, such as through a holding company.

If the 36-month rule does not apply in a home health agency M&A transaction, the general change of ownership and change of information principles described in this practice note will apply.

The Regulatory Process for Change of Ownership Transactions

A transaction classified as a change of ownership, where the buyer has not rejected automatic assignment of the seller's Medicare provider agreement, is meant to facilitate the uninterrupted participation of the provider in the Medicare program. Nevertheless, there are some important regulatory requirements associated with a change of ownership transaction, which are described below.

Notice and filing requirements. Medicare regulation 42 C.F.R. § 489.18(b) requires that a provider considering a change of ownership must notify CMS. This notice is accomplished by the submission by both the buyer and seller of new Medicare enrollment applications to the provider's Medicare Administrative Contractor (MAC). A MAC is a private organization that has contracted with CMS to perform certain functions on its behalf. The new enrollment applications must be submitted prior to the closing, but Medicare guidance prohibits the processing of these materials if they are filed too early (i.e., more than three months before the closing date, in the case of providers).

Review and issuance of "tie-in notice." The MAC reviews the applications and forwards its recommendation and the enrollment applications to the applicable state survey agency (typically the state department of health contracted to perform certain survey functions for CMS). The state survey agency verifies the facts and submits the MAC's recommendations and its own findings to the CMS Regional Office. The CMS Regional Office makes the final decision concerning the change of ownership applications. If it approves the applications, the CMS Regional Office issues a tie-in notice, which associates the Medicare agreement and number of the provider with the new owner. At that point, the new owner may submit claims to Medicare and receive payment using that provider number. It is typical that several months can elapse between the date of submission of the enrollment applications and the issuance of the tie-in notice by the CMS Regional Office.

Prior to their enrollment in Medicare, 42 C.F.R. § 489.13 requires that new providers must undergo a site survey conducted by the state survey agency or an approved accrediting organization. However, in the case of a change of ownership, the provider whose ownership is changing normally is not required to complete a new survey merely by reason of the change of ownership. Yet, if, in connection with a change of ownership, the provider is adding a new location or new services, a survey may be required.

Final cost report filing. Providers are required to prepare and submit an annual Medicare cost report detailing the provider's costs and charges and other data used to make a final determination of the amount of Medicare payment to which the provider is entitled for that year. When a provider undergoes a change of ownership, Medicare regulations require that a seller must file a final cost report covering the period from the end of the prior cost reporting period to the effective date of the change of ownership. The final cost report is due within 45 days of the closing.

Consequences of a Transaction Constituting Change of Ownership

Automatic assignment of Medicare provider agreement. For a transaction classified as a change of ownership, Medicare regulations (42 C.F.R. § 489.18 (c)) provide that the existing provider agreement of the seller will be automatically assigned to the new owner. For most provider types (including hospitals, skilled nursing facilities, and home health agencies), this means that the new owner will also retain the Medicare provider number of the seller. As discussed below, the buyer of a provider in a transaction that would otherwise be classified as a change of ownership is permitted to reject the automatic assignment of the provider agreement and number, in which case the buyer must seek to participate in the Medicare program as a newly enrolling provider.

Delay in Medicare billing and collection. A change of ownership transaction typically results in a delay in the buyer's ability to submit claims to Medicare, thereby affecting the buyer's cash flow. Specifically, until the CMS Regional Office issues the tie-in notice referred to above, the new owner is unable to submit claims in its own name and to receive payment for the post-closing Medicare services that it has furnished. Once the tie-in notice is issued, the buyer can then submit claims and receive payment for services furnished by the provider after the closing. Because it can take several months for the CMS Regional Office to process the Medicare enrollment applications and issue the tie-in notice, the new owner's claims submission—and therefore its receipt of Medicare payments—can be delayed.

This delay in payment is a principal reason why buyers sometimes prefer to structure transactions so that they are classified as involving a change of information, rather than a change of ownership. When the parties cannot structure a transaction as a change of information, or when they decide that there are other factors that favor a structure that is classified as a change of ownership, the buyer can sometimes shorten the time between closing and the tie-in notice by causing the enrollment applications to be filed as early as possible and by ensuring that the enrollment applications are properly and fully completed.

Successor liability for Medicare-related liabilities. An important consequence of the automatic assignment of the Medicare provider agreement in a change of ownership transaction is a buyer's succession to Medicare-related liabilities relating to the pre-closing period. Where successor liability attaches, among other things, Medicare payments to the buyer for post-closing services may be reduced to offset pre-closing Medicare liabilities of the seller. While some transactions classified as changes of ownership, such as asset sales, may not result in successor liability under state law for non-Medicare obligations, a buyer in such a transaction inherits Medicare liabilities under federal law. Specifically, CMS asserts that, unless fraud was involved, the buyer in a change of ownership transaction assumes all the seller's penalties and sanctions under the Medicare program, including repayment of accrued overpayments. Several court cases have supported the imposition of successor liability on a buyer in such transactions for Medicare overpayments and civil money penalties related to the pre-closing operations of the provider. See United States v. Vernon Home Health, 21 F.3d 693 (5th Cir. 1994) and Deerbrook Pavilion, LLC v. Shalala, 235 F.3d 1100 (8th Cir. 2000). While no court cases have addressed successor false claims act liability of a buyer following a change of ownership transaction, buyers have settled cases brought by the government in these circumstances.

There are a number of procedures and mechanisms that a buyer can adopt in order to minimize the risks associated with successor liability in change of ownership transactions. These include:

- Conducting comprehensive regulatory due diligence. The buyer should carefully examine the regulatory compliance of the provider being acquired and assess the potential that any regulatory deficiencies could lead to overpayment liability, civil money penalties, or false claims act liability.

- Requiring the seller to refund payments that it received that are attributable to identified historical compliance lapses, or to self-report those compliance lapses to the government. The most appropriate mechanism for a provider to make a refund or a self-disclosure will depend on the nature of the compliance issues and other facts and circumstances.

- Including in the purchase agreement-specific representations and warranties relating to the provider's compliance with its key Medicare regulatory requirements. These representations and warranties should be tailored to address the particular regulatory risks associated with the type of provider involved.

- Incorporating specific indemnification provisions for Medicare-related liabilities arising from pre-closing operations of the provider, and excluding such indemnities from the "basket," "cap" and other limitations applicable to other bases for indemnification.

- Escrowing a portion of the purchase price as a source of funds to resolve issues that may have been identified, including those where the seller has made a self-disclosure.

A buyer can avoid successor liability under federal law for Medicare-related obligations by rejecting the automatic assignment of the seller's Medicare provider agreement and seeking new Medicare enrollment of the acquired provider. As discussed below in "Consequences of a Transaction Requiring New Enrollment" under New Enrollment, however, there are significant disadvantages to this approach.

Retention of other Medicare attributes. In a change of ownership transaction, as a general rule, the provider retains many of the Medicare attributes that it had prior to the transaction because these attributes are regarded as associated with the Medicare provider agreement that is assumed by the buyer. These attributes, which can affect the provider's future Medicare reimbursement, can be either favorable or unfavorable. For example, if a teaching hospital is sold in a change of ownership transaction, it will retain

any "FTE caps" (essentially, the maximum number of medical residents training at the hospital for which the hospital can obtain Medicare reimbursement) that it had prior to the transaction, thereby enabling the hospital to continue to receive Medicare graduate medical education payments after closing. By contrast, if the buyer rejects automatic assignment and seeks to enroll the hospital as a new provider, it will have no FTE caps initially, and cannot therefore receive Medicare graduate medical education payments. Other attributes, however, may not follow the provider in a change of ownership transaction. For example, if an inpatient rehabilitation unit undergoes a change of ownership, it is treated as a newly enrolled provider for purposes of determining whether the types of patients that the facility treats enables the facility to qualify as an inpatient rehabilitation facility under Medicare. In a given transaction, based on the type of provider, consideration should be given to what attributes will be retained by the provider in order to avoid any unexpected impact on Medicare reimbursement following closing.

Change of Information Transactions

Certain types of transactions do not involve a change of ownership, but rather involve the continuation of the enrollment of an existing Medicare provider. In these transactions, the Medicare enrollment data of a provider may need to be updated as a result of changes resulting from a transaction, and are commonly referred to as change of information transactions.

The most typical change of information transaction is one in which, notwithstanding the transaction, the same legal entity continues to own and operate the provider, even though that entity may be controlled by different persons. In such a case, the provider's enrollment in the Medicare program and its Medicare provider agreement, continue unaffected. Examples of such change of information transactions include the sale of stock of a corporation that owns a provider, or the merger of another corporation into a corporation that owns a provider where the provider corporation survives the merger.

As noted above, the 36-month rule treats certain home health agency transactions differently, requiring the home health agency to enroll in Medicare as a new provider. Transactions that may be affected by the 36-month rule include transactions that would otherwise be treated as a change of information transaction, such as the sale of the majority of stock of the entity that directly owns the provider. Buyers of home health agencies should conduct appropriate due diligence to determine whether the 36-month rule applies and, if so, consider whether the transaction can be structured to avoid the impact of the 36-month rule.

The Regulatory Process for Change of Information Transactions

Notice and filing requirements for change of information. Medicare requires that providers enrolling in the Medicare program furnish certain information and thereafter promptly report any changes to their enrollment information. The required enrollment information includes, among other things, information about the provider's direct and indirect owners, directors and officers, and service locations.

An M&A transaction that does not constitute a change of ownership will typically require the provider to make a change of information filing because the provider's enrollment information will have changed as a result. For example, if all of the stock of a corporation that directly owns a provider is sold, the provider's indirect ownership information will need to be updated through a change of information filing to reflect the new ownership and any other changes.

Providers report changes of information using the Medicare enrollment form, completing only those sections that have changed. Medicare regulation 42 C.F.R. § 424.516(e) requires that updated enrollment information must be submitted within 30 days after any change of ownership or control, and within 90 days after any other changes in the enrollment information.

Consequences of a Transaction Constituting a Change of Information

Continuity of Medicare billing and collection. Since, in a change of information transaction, the entity owning and operating the Medicare-enrolled provider is not changing, the provider's relationship with the Medicare program continues uninterrupted. The provider retains its same Medicare provider agreement and provider number. The provider can continue to bill and collect for services without interruption because Medicare will continue to make payment to the same entity. Thus, unlike a change of ownership transaction, a change of information transaction would normally not result in disruption of the provider's cash flow. This is the main reason that buyers often prefer, when possible, to structure transactions as change of information transactions.

Successor liability and other Medicare attributes. Because, in a change of information transaction, the provider's relationship with the Medicare program is unchanged, the entity owning and operating the provider continues to be responsible for Medicare-related liabilities of the provider, including those attributable to the pre-closing period. As a result, just as in change of ownership transactions, buyers involved in change of information transactions should conduct thorough due diligence concerning the provider's regulatory compliance. The buyer should also utilize appropriate representations and warranties, indemnities, and escrow provisions in the purchase agreement to reduce its risk relating to pre-closing Medicare-related liabilities.

Similarly, in a change of information transaction, the provider retains all of the Medicare attributes associated with the Medicare provider agreement and number. Additionally, no final cost report is required to be filed for the period ending on the closing date.

Acquisitions of Providers to Be Operated under Buyer's Medicare Enrollment

Another type of transaction that may require a change of information filing involves the acquisition of the assets of a Medicare provider by a buyer that is already enrolled in the Medicare program. In such a case, it may be possible for the buyer to operate the acquired business under the buyer's existing Medicare enrollment. In order for the acquired business to be treated as part of the buyer's Medicare enrollment, the post-closing relationship between the acquired business and the buyer may have to meet the standards set forth in Medicare's provider-based rules at 42 C.F.R § 413.65. For example, if a hospital acquires the assets of an entity that had been enrolled as a freestanding ambulatory surgical center, the hospital may be able to operate the surgery center under the hospital's Medicare enrollment, rather than as a freestanding ambulatory surgical center, if the surgery center can be regarded as provider based.

In a case where the buyer will operate the acquired business under the buyer's existing Medicare enrollment, the buyer may need to make a change of information filing to add the acquired business's locations to the buyer's Medicare enrollment. Since the buyer will operate the acquired business under its Medicare enrollment, the buyer would reject automatic assignment of the seller's Medicare provider agreement to prevent the transaction from being treated as a change of ownership.

Under these circumstances, normally the buyer would not have successor liability because the buyer would have rejected automatic assignment of the seller's Medicare provider agreement. Further, the buyer would normally be able to bill for services furnished immediately after the closing date because the addition of a service location to an existing provider does not ordinarily require a new enrollment survey of the additional service location. Thus, in such a transaction, the buyer may be able to both avoid successor liability and any interruption in billing.

Despite the application of these general principles, CMS expressed concern that successor liability can be too easily avoided in cases where a Medicare-enrolled hospital acquires another hospital and seeks to treat it as an additional provider-based service location. In a 2013 Program Memorandum, CMS made it more difficult for hospitals that acquire other hospitals to reject automatic assignment and thereby avoid successor liability. Specifically, CMS has said that, where a hospital acquires another hospital, refuses to accept assignment of the acquired hospital's provider agreement, and simply treats the acquired hospital as an additional service location under the acquiring hospital's Medicare provider agreement, the acquired hospital must follow a process similar to that applicable to an initial applicant for Medicare enrollment, including successfully completing a full site survey. This process could have the effect of creating a gap in payment between the closing date and successful completion of the survey, thereby creating a disincentive for the buyer to reject automatic assignment of the acquired hospital's provider agreement in order to avoid successor liability.

New Enrollment

A transaction that does not constitute a change of ownership or a change of information typically will require a new Medicare enrollment by the entity acquiring the provider. New enrollment can be required where, as noted above, the buyer in a transaction that would otherwise be regarded as a change of ownership rejects the automatic assignment of the provider's Medicare provider agreement. Another scenario that could require new enrollment is where the provider has ceased operations prior to the closing of the transaction. Under Medicare rules, the cessation of operations results in the termination of the provider agreement; if this has occurred, then following closing the buyer would have to seek new enrollment in order to participate in Medicare. See 42 C.F.R. § 489.52(b)(3).

The Regulatory Process for New Enrollment

Notice and filing requirements. A buyer in a change of ownership transaction that plans to reject the automatic assignment of the Medicare provider agreement is required to notify the CMS Regional Office at least 45 days prior to the closing. The new owner can then seek to enroll in the Medicare program as an initial applicant.

The process for new enrollment includes submission of Medicare enrollment forms, review of those forms by the MAC (that makes a recommendation to the CMS Regional Office), and approval of those forms by the CMS Regional Office. Significantly, in the case of a new enrollment, the provider must successfully complete a site survey by the state survey agency, CMS or an acceptable accrediting organization. The survey is usually the final step in the enrollment process. Until it has completed that step, the provider is not enrolled in the Medicare program and therefore it cannot bill Medicare for services furnished prior to the completion of the survey. Therefore, when an M&A transaction requires a new enrollment by the buyer, as discussed below, there will be a gap period between closing and completion of the initial site survey during which the buyer will not be paid for services furnished to Medicare beneficiaries.

Consequences of a Transaction Requiring New Enrollment

No successor liability to Medicare. When an M&A transaction is not a change of ownership or change of information, but rather requires the buyer to enroll in the Medicare program as a new provider, the buyer does not succeed to the Medicare-related liabilities of the seller under federal law. It is for this reason that buyers in change of ownership transactions often consider rejecting the automatic assignment of the provider agreement of the seller, particularly where the risks of Medicare-related liability are perceived to be high, such as where due diligence has discovered significant Medicare compliance lapses by the seller.

Likely loss of Medicare revenue. Review of the enrollment applications and the site survey cannot be completed until after the buyer closes on its acquisition of the provider, and, as noted above, the provider cannot submit claims for payment for services until the initial enrollment process has been completed. This results in a gap between the date of closing and the completion of the buyer's initial enrollment during which the buyer cannot be paid for its services to Medicare beneficiaries.

In the past, seeking to avoid successor liability, buyers have sometimes rejected automatic assignment of the sellers' provider agreements, and then sought to minimize the payment gap associated with a new enrollment by working with the MAC to expedite review of the enrollment applications and coordinating with the state survey agency or accrediting organization to schedule a survey immediately following closing. In 2013, CMS issued instructions to survey agencies and accrediting organizations aimed at making it more difficult to minimize the payment gap, thereby making rejection of the automatic assignment (and the resulting avoidance of successor liability) less attractive.

In particular, CMS's instructions emphasized that:

1. The initial certification following rejection of automatic assignment cannot take place until after the closing date.
2. The survey must be a full, standard survey.
3. The survey cannot take place until after the MAC has issued a recommendation for approval of the buyer's enrollment application (and that the MAC should not complete its review until after the closing date).
4. The applicant must be fully operational with a sufficient number of patients before it may be surveyed.
5. The survey must be unannounced.
6. Initial surveys should be treated as the lowest workload priority by state survey agencies. These instructions leave a buyer with a higher degree of uncertainty as to the amount of lost Medicare payment it will suffer by rejecting automatic assignment of the seller's provider agreement.

Given this uncertainty, buyers in change of ownership transactions typically do not reject automatic assignment of a seller's Medicare provider agreement. Rather, they normally accept assignment, and attempt to deal with the potential for successor liability for pre-closing Medicare-related liabilities in different ways. These include conducting thorough due diligence relating to regulatory compliance, including appropriate representations and warranties and indemnities in the purchase agreement, requiring an escrow of some portion of the purchase price to satisfy those liabilities, and in some cases requiring self-disclosure and/or repayments relating to pre-closing concerns.

Loss of Medicare attributes. When a buyer enrolls an acquired provider as new participant in the Medicare program, the historical Medicare attributes associated with the provider will be lost. As noted above, these can include favorable as well as unfavorable attributes that impact future Medicare reimbursement for the provider's services. A buyer considering rejection of the automatic assignment of the seller's Medicare provider agreement should carefully consider the impact on future revenue and operations of the loss of the historical Medicare attributes of the acquired provider.

Medicaid

Each state administers its own Medicaid program, and develops its own requirements and processes to deal with Medicaid providers that enter into M&A transactions. In some cases, the state Medicaid processes are the same as or similar to those of the Medicare program described above. However, in other cases, the states processes deviate from Medicare.

For example, unlike Medicare, some states require advance notice of a transaction that results in a change of control of the entity owning a Medicaid provider, even though the entity owning the provider remains the same. Also, in some states, the sale of the stock of an entity that owns a Medicaid provider requires the owner to complete a new enrollment in the Medicaid program and the agency will issue a new Medicaid provider number. In some states, an M&A transaction can be completed without an interruption in claims submission and receipt of payment, but in other states, Medicaid claims must be held until the enrollment process has been completed. States also have varied approaches to addressing Medicaid-related successor liability of the buyer of a provider.

Often, a state Medicaid agency's requirements and processes are not fully set out in regulations, but rather are reflected in provider agreements or internal policies. As a practical matter, the best course is often to contact the applicable state Medicaid agencies to discuss the requirements and processes applicable to a particular transaction.