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The End of the Yellow Brick Road: Oz's Fraud-Fighting Agenda Strands New York Healthcare Deals

By Douglas Nadjari
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Consider this: Sam has operated Sam's Pharmacy, a community pharmacy in the Bronx, for thirty-two years. His store fills approximately 1,200 prescriptions weekly, 70 percent of which are reimbursed through New York's Medicaid program. By 2026, Sam is tired and wants out. After much negotiation, he signs an asset purchase agreement with Beyers, selling the pharmacy to him for $2.5 million.

Closing is conditioned on the New York State Department of Health's (DOH) approval of a change of ownership (CHOW) application, which Beyers promptly submits. Sam starts winding down and allows his Medicaid provider number to lapse on April 30, 2026.

On May 1, 2026, DOH announces a six-month moratorium on new Medicaid provider-enrollment and CHOW applications for provider categories designated as "high risk" by the Centers for Medicare and Medicaid Services (CMS), including pharmacies. The moratorium takes effect immediately and encompasses pending applications, including Beyers's. DOH has halted the CHOW process.

Beyers is stuck in limbo, and, by the same twist of fate, Sam cannot reinstate the lapsed provider number. Neither Sam nor Beyers can bill Medicaid or operate as a Medicaid-enrolled provider. The moratorium and the havoc it wreaks are existential for the pharmacy and disruptive to the Medicaid-dependent patients it serves, including children and those taking anti-retroviral medications.

Medicaid

This scenario is not far-fetched. Recently, the New York State Department of Health (DOH) imposed an immediate six-month moratorium on both new Medicaid provider enrollments and the processing of change of ownership (CHOW) applications involving provider categories identified as "high risk" by CMS.

The moratorium is effective immediately, is expected to remain in place for approximately six months and applies to transactions and changes of ownership for: (i) clinical laboratories, (ii) durable medical equipment, (iii) prosthetics, orthotics and supplies suppliers, (iv) applied behavior analysis providers, (v) licensed Home Care Services Agencies, (vi) pharmacies, and (vii) managed long-term care plans.

The moratorium stems from action taken by CMS Administrator Mehmet Oz, who, in April of this year, mandated an accelerated change to a process known as "revalidation"—a process by which each state verifies that a Medicaid provider's enrollment information, credentials, and practice meet Medicaid program participation standards.

All enrolled providers, whether individual or institutional, must be screened both at initial enrollment and at revalidation. States can determine the cadence of revalidation, but all providers must be revalidated at least once every five years. Federal regulations require State Medicaid agencies to revalidate all provider enrollments at least every five years.

Traditionally, this occurred at a pace and cadence controlled by each state and typically dependent upon the last revalidation date. CMS and Dr. Oz have mandated a radical departure from that process,

requiring every state to revalidate all enrolled Medicaid providers within 24 months. This is a herculean task indeed, given that there are over 240,000 providers in New York State and precious few resources to revalidate so many simultaneously.

CMS encouraged states to implement temporary enrollment moratoriums for higher-risk provider classes. Indeed, by letter sent to the governors of all fifty states, Oz "request[ed] that your Medicaid program undertake a swift revalidation of Medicaid providers of services at high risk of waste, fraud, abuse, and corruption."

The moratorium imposed by New York is limited to the high-risk categories cited by CMS and stops the clock for new applicants, those seeking revalidation, and transactions involving changes of ownership. It applies without regard to the stage of review or the status of any affected deal—even those completed and pending administrative review.

Indeed, while the moratorium is ongoing, DOH will process neither new enrollment nor any CHOW applications. Subsequent guidance provided by DOH confirmed this, noting that ownership-related enrollment changes will not be processed either and, moreover, that pending enrollment applications for the listed providers will be discontinued, requiring new applications once the moratorium is lifted.

The moratorium has immediate consequences for mergers and acquisitions, private equity investments, financing, joint ventures, and other transactions involving the businesses encompassed by the moratorium. Additionally, many healthcare transactions require post-closing modifications to Medicaid enrollment records or regulatory approval of ownership changes. Accordingly, closing timelines may be delayed until the moratorium ends.

Notably, not every transaction involving an affected provider will necessarily be impacted. Certain transaction structures may avoid the need for either a new enrollment or CHOW, thus side-stepping the moratorium.

DOH intends to publish Frequently Asked Questions and additional guidance to address implementation issues, but in the interim, "deal-threatening" questions loom large. Businesses that fall within the moratorium's ambit should promptly evaluate the practical and regulatory consequences of any pending or contemplated transactions. Attention should be given to:

· Transaction planning to determine whether Medicaid enrollment requirements or CHOW approval, now delayed, could prevent or delay a transaction.

· Whether alternative transactional structures could facilitate a prompt closing.

· Revisiting transaction timelines, closing conditions, financing commitments, and investor expectations.

· If the purchase agreement contains a force majeure clause encompassing governmental actions or regulatory changes, the moratorium may excuse one or both parties' performance obligations. Agreements should be carefully reviewed for the effect of such provisions on buyers and sellers alike.

· In the absence of such a clause, the common-law doctrines of impossibility and frustration of purpose may apply.

· Taking a hard look at regulatory risk allocation provisions in purchase agreements and financing documents.

New York has characterized the suspensions as temporary, but the moratorium could be extended and injects real uncertainty into myriad healthcare transactions. Given what may be at stake, the potential for litigation cannot be overlooked-despite a lack of directly applicable precedent.

Failure to comply with Secretary Oz's request for expedited revalidation could jeopardize federal

funding. Thus, while the request may seem coercive, it is not binding. New York's self-imposed moratorium looks and operates like a "rule," as defined by SAPA §102(2)(a). New York courts have consistently held that the adoption of administrative rules that do not comply with SAPA rulemaking procedures (i.e., notice, publication, comment period, etc.) may be subject to challenge.

Absent notice, public comment, and adherence to other details attending the rulemaking process, the moratorium could be subject to challenge. In addition, since the high-risk classification of affected businesses is not based upon any articulable suspicion of individualized risk, the moratorium could, by virtue of its broad sweep across industry sectors, be subject to an overbreadth challenge.

In either case, state court challenges could be brought pursuant to CPLR Article 78, which authorizes challenges to actions (and inactions) of state agencies and local governments. Article 78 proceedings are not automatically deemed expedited or extraordinary proceedings, and from a practical perspective, litigation could easily outlast the six-month moratorium.

Accordingly, would-be applicants should consider proceeding by order to show cause, seeking a preliminary injunction or temporary restraining order under CPLR Article 63. Any party seeking such relief must demonstrate: (i) a likelihood of success on the merits, (ii) danger of irreparable harm in the absence of an injunction, and (iii) a balance of the equities in favor of the injunction.

Accordingly, movants should cite the lack of a federal directive and articulate the impact the action could have upon the loss of continuity (particularly in underserved communities), the effect upon employees, and the loss of goodwill, patient relationships, or customer relationships.

Since the moratorium was imposed absent procedural due process, potential litigants should also consider—although it is a bigger stretch—whether it constitutes a deprivation of property and thus violates both the Fourteenth Amendment of the U.S. Constitution and Article 1, Section 6 of the New York State Constitution.

To prevail, one would first need to overcome the deference afforded by courts to the government for actions in highly complex and regulated industries such as healthcare. Further, courts traditionally do not apply a bright-line standard for distinguishing between permissible exercises of state power and "unconstitutional impositions" (or takings), noting the absence of any set formula "for determining how far is too far." Rather, courts must engage in "ad hoc factual inquiries" when presented with takings claims.

In determining whether there has been an unconstitutional taking, courts have examined: (i) whether the action delivers catastrophic financial loss (and not simply a reduction in potential profit or a delay in the transfer) and (ii) whether the action complained of is an adjustment for reasons of public good as opposed to an actual taking.

While the moratorium was driven by the federal government and adopted by New York and may have been conceived as a temporary program-integrity measure, its immediate effect is far from routine and could prove to be anything but temporary for many.

A pause of six months or longer could close businesses, scuttle deals (or grossly alter deal value), disrupt financing, strand pending transactions, and threaten continuity of care for those Medicaid is meant to protect. Until DOH provides clearer guidance, affected parties should treat the moratorium as a front-end diligence, structuring, and litigation-risk issue that demands early assessment, careful drafting, and—while an uphill climb—litigation for the right client.

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