

# State Policies to Protect Physicians from Corporate Control

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# Overview

- **Models of corporate control over physicians: the Management Services Organization (MSO)**
  - Core functions of MSOs
  - The MSO–professional corporation (PC) arrangement and the “friendly physician” model
- **Policy concerns of corporate MSO control of physicians**
- **Policy Options**
  - Strengthening the Corporate Practice of Medicine prohibition
  - Banning physician noncompete, nondisparagement, nondisclosure clauses
  - Ownership transparency

# Corporatization and Physician Practice: The MSO

**Definition:** An MSO is an entity that provides non-clinical services to physician practices. MSOs are the primary vehicle through which lay-corporations acquire control over medical practices

MSOs originally provided back-office administrative support. The MSO worked for the practice.

But now, MSOs facilitate corporate investment and exert control over practices. The practice works for the MSO.

MSOs used to bypass state prohibitions on the corporate practice of medicine (CPOM), allowing large corporations to functionally own medical practices and influence clinical care.

Issue Brief  
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Milbank  
Memorial Fund  
*Using evidence to improve population health*

## The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices

Hayden Rooke-Ley, Megha Reddy, Neil Mehta, Yashaswini Singh, and Erin Fuse Brown, Center for Advancing Health Policy through Research, Brown University School of Public Health

### Policy Points

- > Require management service organizations (MSOs) and physician practices to disclose financial backers, ownership structures, and contractual affiliations to state regulators.
- > Strengthen state authority by requiring prior notice and review of MSO transactions, with power to block or place conditions on transactions without a court order and

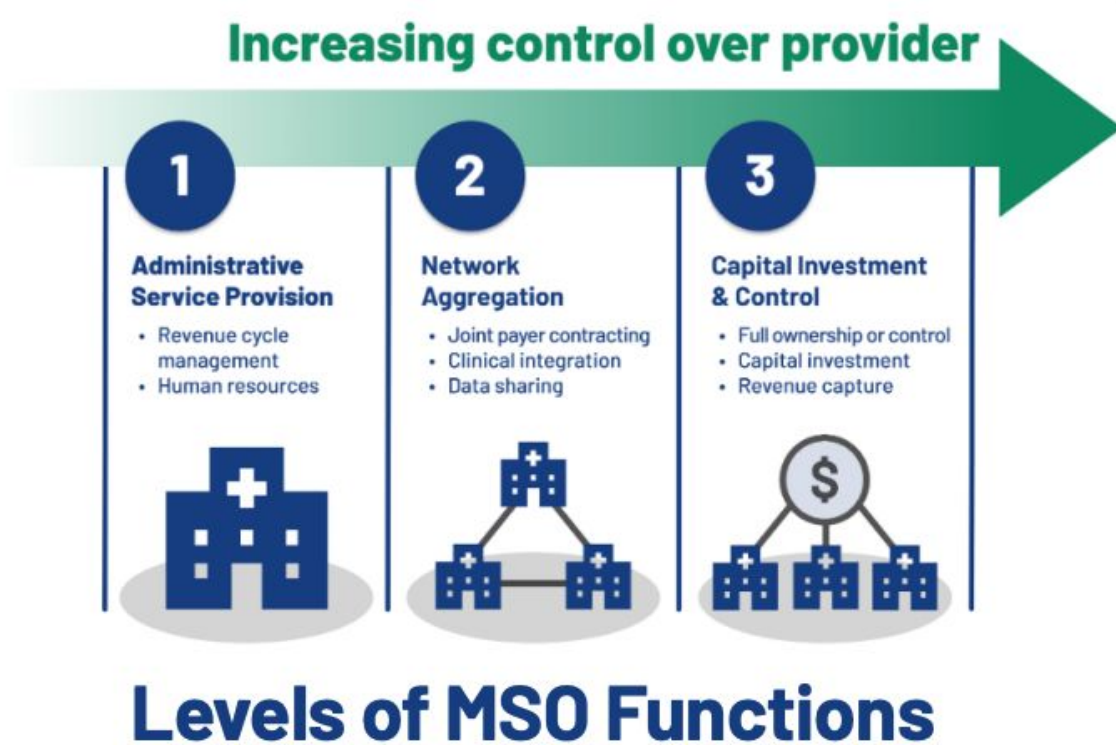
### ABSTRACT

Management service organizations (MSOs) have evolved into powerful corporate vehicles for consolidating physician practices. Originally designed to handle billing, human resources, and other back-office administrative tasks, MSOs now aggregate medical groups, negotiate payer contracts, and facilitate corporate investment – often blurring the line between support and control. Increasingly, private equity firms, insurance companies, and other corporate entities are using MSOs to bypass state prohibitions on the corporate practice of medicine (CPOM), allowing large corporations to functionally own medical practices and influence clinical care.

This brief examines the expanding role of corporate MSOs, their impact on health care delivery and market consolidation, and the regulatory gaps that allow them to operate with minimal oversight. Though corporate-backed MSOs may offer enticing capital investments in physician practices, unchecked MSO influence threatens to prioritize profits over patient care, weaken competition, and erode physician independence within the health care system. To address these concerns, we explore state-level policy solutions to enhance financial transparency, strengthen oversight of MSO transac-

Source:  
<https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/>

# Core Functions of MSOs



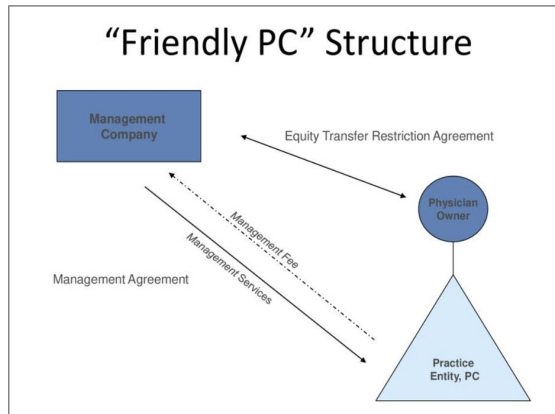
Source:

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# Corporate Control Via Management Services Org. (MSO)

**MSO Contract Model:** Corporate-owned MSO contracts to run the physician practice through a management services agreement

**Friendly PC Model:** MSO installs “friendly physician” to run, and often to exclusively own, the practice. The friendly physician is a straw owner who works for the MSO, who may not provide any patient care in the practice.



American Health Law Association Presentation (2017)

## Ways in which a corporate MSO exerts control:

- Financial control (compensation) over friendly physician;
- Stock restriction agreements, non-competes, gag clauses;
- Hiring/firing physicians and clinical staff, compensation, terms of employment;
- Setting work schedules and staffing levels;
- Dictating patient volume, visit length, diagnostic codes;
- Establishing clinical standards and protocols;
- Billing and collection policies; and
- Controlling payer contracting.

# Examples of Corporate MSOs

- **Insurance company:**
  - UnitedHealth Group-Optum
  - Humana-CenterWell
- **Retailer:**
  - CVS / Aetna – Oak Street Health
  - Amazon – One Medical
- **Private Equity/Investor Backed**
  - Walgreens / Cigna – Summit Health\* (all 3: insurer, PE, retailer)
  - ChenMed
  - Privia
  - Envision, TeamHealth
  - United Urology



# Policy Concerns of Corporatization of Physicians

## Policy Concerns

- Consolidation of physician practices → higher prices
- Erosion of professional autonomy, morale, and trust
- Pressure to put profits over patients
- Physician exit from burnout, retirement, practice
- Disruption in the physician-patient relationship
- Chills physicians from speaking out or leaving (bound by non-competes, gag clauses)
- Equity concerns – disproportionate impact on safety net providers
- Competitive concerns – pressure to steer patients, self-preferencing by insurer-owned practices



# Policy Options to Address Corporatization of Physicians

## Policy Approach

## Policy Concerns



**Strengthening the Prohibition on  
Corporate Practice of Medicine**

Professional autonomy,  
workforce effects,  
interference with clinical  
decision-making



**Ban Restrictive Employment Clauses:  
Noncompetes, Nondisclosure,  
Nondisparagement**

Clinical workforce  
mobility and supply



**Transparency of Ownership and Control**

Opacity, lack of  
accountability



# Policy: Strengthening the Corporate Practice of Medicine Prohibition

## Policy Concern

Corporate control over physicians and other independent practitioners (e.g., PE, Optum, etc)

## What it is?

The Corporate Practice of Medicine (CPOM) doctrine generally bans unlicensed lay entities from owning, employing, or controlling medical practices. Stems from bans on the unlicensed practice of medicine.

**What it isn't:** CPOM does not address corporate/for-profit control of *hospitals* or other facilities

## Why strengthen it?

CPOM laws eroded over time, with exceptions (HMOs, Hospitals) and nonenforcement.

Corporations contractually circumvent CPOM bans to exert *de facto* control over a medical practice they did not formally own through MSOs and friendly physician.



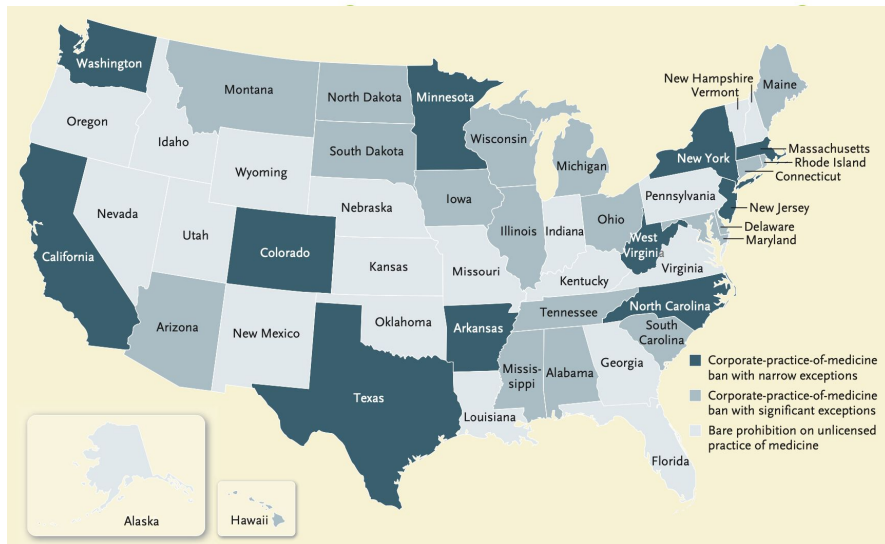
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PERSPECTIVE



## A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine



Source: Zhu J, Rooke-Ley H, Fuse Brown E. 2023. *A doctrine in name only—strengthening prohibitions against the corporate practice of medicine*. NEJM 389(11): 965-968.

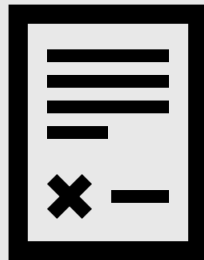
# Why CPOM Legislation May Be Helpful



## Codify Guidance and Case Law

Clarify the scope of CPOM

- Who does it apply to?
- Who may own or control medical practices?



## Address Contractual Workarounds

Clarify conduct and contract terms by MSOs (e.g., friendly physicians, contractual controls) that implicate CPOM



## Improve Enforcement

Allow private enforcement by employees or competitors to function as private attorneys general

# NASHP Model: Strengthening CPOM, Banning Noncompetes

## Add or clarify CPOM prohibition in statute

Prohibit unlicensed lay-entities from owning, employing, or controlling medical practices

Prohibit any unlicensed lay-entities from interfering with clinical decisions

## Regulate Friendly PC/MSO structure (does not ban MSOs)

Restrict dual compensation / control of PC and MSO, require “meaningful presence”, and ban stock-transfer restrictions (to address “friendly physician”)

Require that licensed professionals maintain ultimate control over clinical and business decisions in contracts with management services organizations (MSOs)

Enumerate types of clinical and business decisions that implicate CPOM

Ban or limit non-competes, gag-clauses

## Protections for employed physicians (e.g., by hospitals or other exempted entities)

Ban or limit non-competes, gag-clauses

Noninterference with clinical decisions: time with patients, diagnosis, referrals, status, coding, etc.

## Multiple routes of enforcement: AG, administrative agency, private actions

Administrative enforcement by AG, health agency, or both

Private enforcement (by aggrieved employee or competitor) can supplement administrative enforcement, as a whistleblower

# Unpacking CPOM – Addressing friendly physician

Banned arrangements (per se violations of CPOM law):

- **Straw Ownership:** Licensed owners must exhibit meaningful ownership, be duly licensed and present in the state, and be substantially engaged in delivering care or managing the practice.
- **Dual Ownership or Interests:** To prevent a direct financial conflict of interest, licensed medical providers generally could not be shareholders, directors, or employees of a lay-owned MSO with which their medical practice contracts.
- **Stock Transfer Restriction Agreements (STRAs):** MSOs could not bind physician practices to STRAs, which place the MSO in control of the physicians' ownership interests in the practice.

# Unpacking CPOM – Regulating PC/MSO Contracts

Non-exhaustive list of activities or decisions that the practice must retain **ultimate decisionmaking authority** over (but may be performed by MSO):

- **Staffing and Patient Time:** Decisions concerning hiring, firing, terms of employment, or staffing levels of licensed medical providers, as well as decisions that implicate the amount of time providers spend with patients;
- **Disbursement of physician fee revenue, control over budgets;**
- **Standards and Coding:** Clinical standards and policies, and diagnostic coding practices and billing practices; and
- **Prices and Payers:** Prices and rates charged for services at the practice, decisions to contract with third-party payers, and the structure of such contracts.


# Unpacking CPOM – Protections for Employed Physicians


For corporate entities (e.g., hospitals) that employ physicians:

- **Restrictive covenants prohibited** (noncompete, NDAs, nondisparagement)
- **No interference with professional judgment or clinical decisions of a licensee** through discipline, adverse employment action, retaliation, threats, or coercion, regarding:
  - Time spent with patients
  - Discharge times
  - Patient clinical status (e.g., admitted, observation, palliative) and referral decisions
  - Diagnoses, diagnostic terminology, codes, documentation
  - Limiting the range of clinical orders or options available
  - Other actions specified by regulation


# Policy 3: Strengthening CPOM – VT H.583


## Add or clarify CPOM prohibition in statute


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## Regulate Friendly PC/MSO structure (does not ban MSOs)

 Restrict dual compensation / control of PC and MSO, require “meaningful ownership”, and ban stock-transfer restrictions (to address “friendly physician”)


 Require that licensed professionals maintain ultimate control over clinical and business decisions in contracts with management services organizations (MSOs)


 Enumerate types of clinical and business decisions that implicate CPOM

 Ban or limit non-competes, gag-clauses


## Protections for employed physicians (e.g., by hospitals or other exempted entities)


Exempted entities: safety net entities, public entities, **nonprofit hospitals, ASCs**

 Ban or limit non-competes, gag-clauses

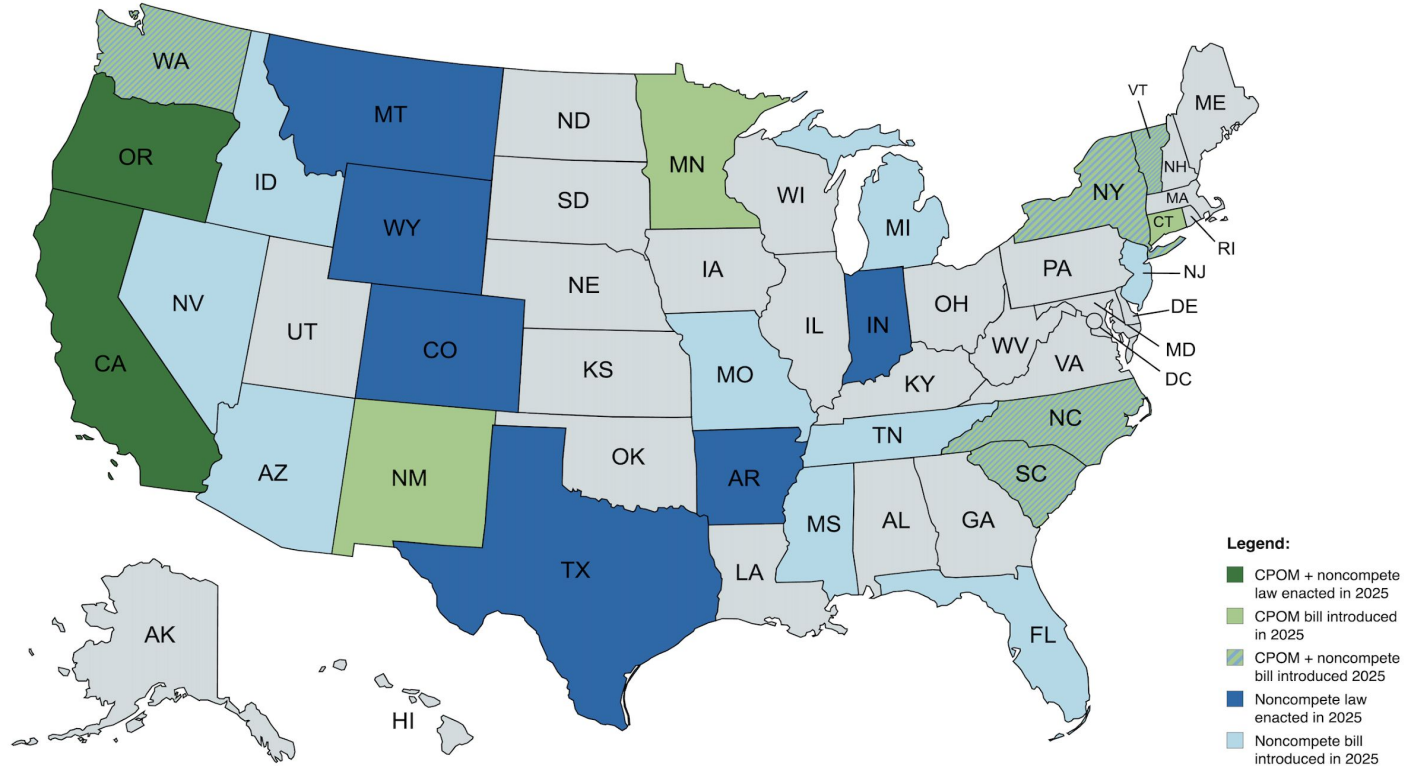
 Noninterference with clinical decisions: time with patients, diagnosis, referrals, status, coding, etc.

## Multiple routes of enforcement: AG, administrative agency, private actions

 Administrative enforcement by AG

 Private enforcement (by aggrieved employee or competitor) can supplement administrative enforcement, as a whistleblower

# 2025 Legislative Action on CPOM, Noncompetes





# Policy: Transparency of Ownership and Control

- Require all existing health care entities to **report information** on owners, controlling entities, and business structure, including the ultimate owners or controlling parent, subsidiaries, entities under common control, and any MSOs
- Require all health care entities to **report any *changes* to ownership or control**
- Make this information **available to the public**
- **Required Information:** Name, location, TIN, NPI, EIN, CCN, NAIC, owners, significant equity investors, control entity, MSO, corporate org chart, subsidiaries, entities under common control, financial reports

# NASHP Model Part III: Transparency of Ownership/Control

Part III of NASHP Model requires health care market participants to report ownership and control to the Department of Health or other designated state health care entity.

- **Applicability:** group practices, hospitals, health systems, nursing facilities, insurers, PBMs , MSOs, “significant equity investors”
- **Frequency:** Annually and upon change of ownership
- **Required information to be reported:** Name, location, TIN, NPI, EIN, CCN, NAIC, owners, significant equity investors, control entity, MSO, corporate org chart, subsidiaries, entities under common control, financial reports
- **Reporting:** Public reporting and inter-agency data sharing
- **Enforcement:** DOH/Health Commission administrative penalties, audits

# VT H.583: Transparency of Ownership/Control

Part III of NASHP Model requires health care market participants to report ownership and control to the Dep't of Health or other designated state health care entity.

- ✓ • **Applicability:** group practices, hospitals, health systems, nursing facilities, insurers, PBMs, MSOs, “significant equity investors”
- ✓ • **Frequency:** Biannually and upon any material change transaction\*
- ✓ • **Required information to be reported:** Name, location, TIN, NPI, EIN, CCN, NAIC, owners, significant equity investors, control entity, MSO, corporate org chart, subsidiaries, entities under common control, financial reports
- ✓ • **Reporting:** Public reporting and inter-agency data sharing
- ✓ • **Enforcement:** Attorney General under Consumer Protection Act, ~~audits~~

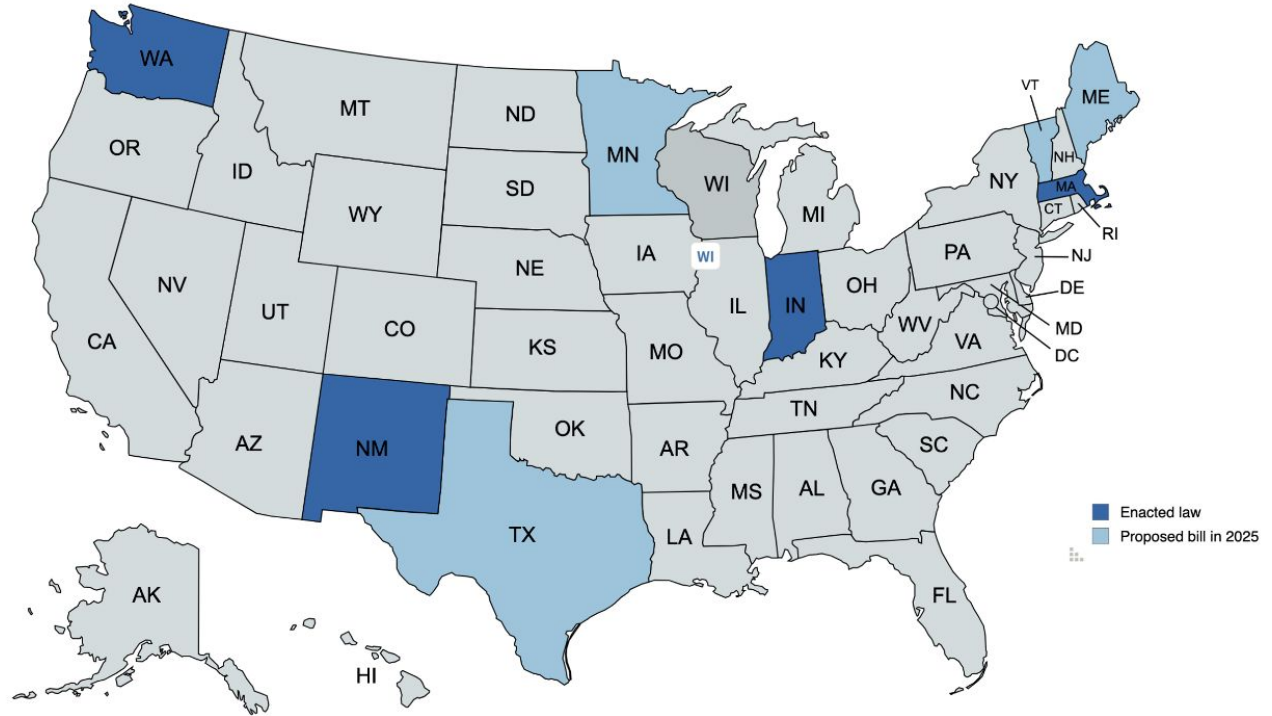
# State Ownership Transparency Laws/Bills (2025)

## Passed:

- IN: HB 1666
- MA: Ch. 343 of Laws of 2024
- NM: SB 14
- WA: HB 1686

## Introduced:

- ME: HP 1316
- MN: HF 2779
- TX: HB 4408
- VT: H 71





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