CORPORATE PRACTICE OF MEDICINE: USING AN OLD DOCTRINE TO THWART THE NEW THREAT OF PRIVATE EQUITY TO MEDICINE IN AMERICA

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ABSTRACT

Private equity owns large swaths of the American economy. States have grappled with this shift in ownership—and the accompanying fundamental business and economic changes—by drafting legislation designed to regulate M&A activity in certain industries. Often, states have tried to curb the influence of private equity in healthcare, an industry both particularly ripe for private equity investment and one long seen as particularly vulnerable to the worst of market economics. Recently, some states have drafted or enacted "mini-HSR" legislation: mandating a waiting period for private equity transactions in healthcare during which the state may approve or disapprove the deal (HSR stands for the Hart-Scott-Rodino Act, a core federal antitrust law). But an older rule may be more useful in curbing private equity's attempts to own healthcare companies: the Corporate Practice of Medicine (CPOM) doctrine. Over a century old, this doctrine disallows corporations from practicing medicine. Traditionally, CPOM applies to individual practices and generally forbids anyone but a physician from making care-based decisions. CPOM originated in a far simpler world of corporate regulation (and medicine) and has come under scrutiny in modern times. But the essence of CPOM—that healthcare must be free from the control of purely financially motivated actors—seems to answer the calls of state legislatures to prevent private equity from running American healthcare. This Note will examine private equity's interest in healthcare and the threat it poses to healthcare, track the CPOM doctrine through its history of enactment and enforcement, analyze recent states' "mini-HSR" anti-private equity efforts, and finally recommend that courts enforce the CPOM doctrine using the practical approach articulated in Flynn Bros.

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Private equity firms are taking over our country, buying up hospitals, emergency rooms, nursing homes, childcare facilities . . . . Unacceptable. These vultures cannot be allowed to take over America.[1]

-Bernie Sanders

I'm proud of real capitalists, . . . But not particularly proud of people who go in, leverage the game, borrow the money, leave the debt behind and walk off with all the profits.[2]

-Newt Gingrich

INTRODUCTION

Americans recently held the most pessimistic view of their healthcare system in decades.[3] During that period, private equity continued to "surge" into healthcare in America.[4] This presents challenges on various levels.[5] Foremost, private equity—perhaps notoriously—finds ways to raise profits by spending less and charging more, resulting in cheaper care for higher prices.[6] That Americans' feelings about their healthcare have deteriorated as private equity's involvement in that care has risen is not coincidental. Many states recognized this effect and have made efforts to combat it, principally

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[1] Video posted by Bernie Sanders (@berniesanders), FACEBOOK, *Private Equity Firms Are Taking Over Our Country, Buying Up Hospitals, Emergency Rooms, Entire Neighborhoods.* (Oct. 28, 2024), https://www.facebook.com/berniesanders/videos/private-equity-firms-are-taking-over-our-country-buying-up-hospitals-emergency-r/3783285061922494/ [https://perma.cc/FQ2N-CUER].

[2] Lisa Lerer, Devin Banerjee & Erik Schatzker, *Newt Gingrich Was Paid $60,000 for Speech Praising Private Equity*, WASH. POST (Jan. 18, 2012), https://www.washingtonpost.com/politics/gingrich-paid-60000-for-speech-praising-private-equity/2012/01/18/gIQA63nK9P_story.html [https://perma.cc/L3P6-B95J] (noting Gingrich ran anti-private equity ads in the presidential primary, targeted against Mitt Romney, but it was then discovered that Gingrich was friendly to private equity).

[3] In 2024, Americans held the most negative view of the American healthcare system since 2001. Megan Brenan, *View of U.S. Healthcare Quality Declines to 24-Year Low*, GALLUP (Dec. 6, 2024), https://news.gallup.com/poll/654044/view-healthcare-quality-declines-year-low.aspx [https://perma.cc/QK5U-MT37].

[4] *See* Nirad Jain et al., *Healthcare Private Equity Market 2024: Year in Review and Outlook*, BAIN & CO. (Jan. 9, 2025), https://www.bain.com/insights/year-in-review-and-outlook-global-healthcare-private-equity-report-2025/ [https://perma.cc/EGA8-2WCH].

[5] *See* Scott C. Kessenick, *Double-Edged Sword: The Role of Private Equity in Healthcare, and Increased Regulatory Scrutiny*, KESSENICK GAMMA, https://kessenick.com/the-role-of-private-equity-in-healthcare-and-increased-regulatory-scrutiny/ [https://perma.cc/K75D-5T67] (last visited Feb. 4, 2026).

[6] *Id.*

via enhanced state oversight over private equity purchases in the healthcare industry.[7] The rationale is that so long as state attorneys general can review transactions in healthcare, they can keep tabs on private equity's spread in their respective states' healthcare economy.[8] This approach recognizes the threat but stops at awareness, failing to provide actionable legal remedies for both the state and private actors.

This Note will examine and propose a different solution to the problem of private equity spreading throughout healthcare in America: corporate practice of medicine (CPOM) laws. CPOM laws—often uncodified—are derived from common law and dictate that only licensed physicians may practice medicine.[9] In plain English, the only people who may own medical practices are physicians themselves. Naturally, this complicates private equity ownership of healthcare companies, but workarounds are being used now.[10] CPOM laws have been considered antiquated by some scholars for decades (far before private equity's rise to prominence in the healthcare industry).[11] But there may be a budding movement of support for CPOM laws, along with more modern state-level antitrust laws, that can be reenergized to help build a beachhead against private equity gaining further control of American healthcare.

This Note will proceed in three parts: first, it will seek to establish the problems with private equity control of healthcare companies; second, it will examine CPOM laws around the country, their application, and their potential shortcomings; and third, it will recommend a reemphasis on CPOM to focus on curbing private equity investment in healthcare.

I. WHAT'S THE BIG DEAL ABOUT PRIVATE EQUITY?

As of 2022, private equity managed over $6 trillion of capital.[12] For some perspective, that's enough money to buy all 32 NFL teams (at their estimated

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[7] Minna Lo Naranjo et al., *Growing Number of US States Target Private Equity Transactions in Healthcare*, MORGAN LEWIS (Aug. 28, 2024), https://www.morganlewis.com/pubs/2024/08/growing-number-of-us-states-target-private-equity-transactions-in-healthcare [https://perma.cc/8EUG-5MT9].
[8] *Id.*
[9] Wright W. Crawford, *Private Equity Investment and the Corporate Practice of Medicine in North Carolina*, 28 N.C. BANKING INST. 527, 532–33 (2024).
[10] *Id.* at 535–37 (outlining current workarounds for private equity to own healthcare companies without tripping CPOM wires).
[11] Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 470–71 (1987).
[12] Chris Morran & Daniel Petty, *What Private Equity Firms Are and How They Operate*, PROPUBLICA (Aug. 3, 2022, at 05:00 ET), https://www.propublica.org/article/what-is-private-equity [https://perma.cc/2Z43-M9J6].

valuations)—more than 32 times over.[13] In other words, a ton of money lies in the hands of private equity funds. So, what does it actually mean to "manage" that much money?

A. How Private Equity Functions

Private equity is less flashy than other finance sub-industries and is a far cry from the often-referenced *Wolf of Wall Street*. In a nutshell, private equity manages money by buying a controlling interest in a business, running the business, then selling the business at, ideally, a higher price than it was originally purchased for.[14] In contrast, venture capital (VC) funds provide early seed funding for less than a controlling interest in startups, in the hope that one day a fraction of the startups will hit it big, go public, and thus generate an exponential return on the VC's initial investment.[15] Hedge funds make money via real-time trading of public markets, often using proprietary trading algorithms.[16] What private equity lacks in exciting startup investment or the rush of split-second trades, it makes up for in returns.

Over nearly a quarter-century, one study found that private equity returned 11.0% annually.[17] In contrast, the stock market returned 6.2%.[18] Consistent above-market returns for investors means that private equity can comfortably charge high fees for its management. The standard fee structure is "two and 20": in other words, the private equity fund collects annual fees in the amount of 2% of total assets managed.[19] So if an investor gives private equity $1,000,000 to manage, the investor pays $20,000 every year for the management, regardless of if the money is deployed or not. Then the private equity company keeps 20% of the profits from the sale of one of its portfolio

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[13] *Franchise Value of National Football League Teams in 2025*, STATISTA, https://www.statista.com/statistics/193534/franchise-value-of-national-football-league-teams-in-2010/ [https://perma.cc/FRM7-RUGZ] (last visited Feb. 4, 2026).

[14] For a more detailed discussion of the private equity business model see Morran & Petty, *supra* note 12.

[15] *Id.*

[16] Andreas Vetsch, *Financial Markets Algorithmic Masterpieces: The Evolution of Systematic Hedge Funds*, LGT (Sep. 10, 2024), https://www.lgt.com/global-en/market-assessments/insights/financial-markets/algorithmic-masterpieces-231988#:~:text=Hedge [https://perma.cc/94XL-YCQP].

[17] Stephen L. Nesbitt, *Long-Term Private Equity Performance: 2000–2023*, CLIFFWATER (Jan. 26, 2024), https://8357303.fs1.hubspotusercontent-na1.net/hubfs/8357303/Research/Cliffwater%20Research%20-%20Long-Term%20Private%20Equity%20Performance%202000-2023.%20Jan%2026%202024.pdf?_hsmi=291754259&_hsenc=p2ANqtz-8s9khHZMXzjDRJZYDfcL4YZxY5ZC_WvDhX98K2O-90e3Cbgn4xMFXxLDdQYZpttFJAtgvhJ8zoLGw1PM1F_oXv7O5I2Q [https://perma.cc/X5R9-4WKC].

[18] *Id.*

[19] Morran & Petty, *supra* note 12.

businesses.[20] If this sounds high, one need only run the simple math comparing stock market returns to private equity returns, minus the fees, to see that investors in private equity still very much come out ahead.

But where do all these profits come from? First, a business is identified. These businesses are often privately held (except in cases of very large private equity funds, which have the capital to explore more expensive public companies, as well as private).[21] Businesses ripe to be targeted often have gaps between realized and potential performance that are relatively easy to identify—this is because private equity funds want to be able to turn around and resell the business they acquire in typically five-to-seven years.[22] Once the business is identified, the purchase is initiated. Private equity funds most often use leveraged buyouts, or LBOs.[23] An LBO operates by using a mixture of debt and equity (but mostly debt—typically 90%) to purchase a company.[24]

Why all the debt? Consider an example: imagine Investor A, who purchases a lemonade stand for $10, then sells the lemonade stand for $15 after a couple years of successful operations. Investor A purchased the lemonade stand with equity, so she would return $15 on her initial $10 investment—a return on equity of 50%. Not bad! But now imagine Investor B, who purchased the lemonade stand with $1 of equity and $9 of debt, then also sold his lemonade stand for $15. After repaying the $9 in debt, Investor B would have returned $6 on his initial $1 investment—a return on equity of 500%. Much better. And, the debt itself is backed by the assets of the business, enabling a failed lemonade stand-owner Investor B to more easily walk away. Finally, imagine the balance sheet of Investor C who buys not one but dozens of lemonade stands with this debt-heavy approach. He will have tons of debt and will seek to protect himself and his debt-laden aggregate position rather than a single lemonade stand. Private equity employs Investor C's approach on a much grander scale.[25]

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[20] *See id.*
[21] *What Is Private Equity and How Does It Work?*, MOWERY & SHOENFELD (Sep. 23, 2025), https://www.msllc.com/insights/blog/what-private-equity/ [https://perma.cc/2Z43-M9J6].
[22] *Understanding Private Equity*, SCHRODERS, https://www.schroders.com/en-au/au/adviser/resources/understanding-private-equity/ [https://perma.cc/CA7R-52L7] (last visited Feb. 4, 2026).
[23] Ryan M. Newburn, *The Art of the Leveraged Buyout*, NEWBURN L. (July 12, 2022), https://www.newburnlaw.com/the-art-of-the-leveraged-buyout/ [https://perma.cc/UK2L-UGSH].
[24] *Id.*
[25] *Id.*

In addition to maximizing debt to increase returns, private equity funds also make money via dividend payments and increasing multiples from purchase to sale.[26] As the controlling shareholder in the portfolio company, the private equity fund—acting as the board of directors—can elect to pay out dividends to the company's shareholders: the private equity fund.[27] Often, the money for these dividends comes from the portfolio company taking out debt to fulfill its new dividend obligation.[28] Not surprisingly, the increased leverage from these loans—and the subsequent interest payments, which are in addition to the interest payments the portfolio company is paying on the debt the private equity fund used to acquire it—can severely hamper the portfolio company's operations.[29] And private equity companies seek to increase the multiple on the sale of the business from the multiple used when purchasing it.[30] When a business is purchased, its value is usually calculated by multiplying its annual profits by a certain number, the "multiple." The specific number used as the multiple is determined by the business's industry, its size, and the strength of its operations.[31] Naturally, if a private equity fund can find a way to both increase profits and increase the multiple from purchase to sale on a business, then the money starts to explode.[32]

Finally, it should not be overlooked that perhaps the core of private equity's publicly stated mission in acquiring a business is to increase its profits.[33] This happens by bringing in highly-skilled operators to run the business, streamlining operations, selling off appropriate divisions, and generally getting leaner.[34] But more often, particularly for larger private equity funds, the money comes from financial engineering and reselling portfolio companies to other private equity funds—who plan to rinse and repeat the process.[35] The funds intend this process to take less than a decade (often five-to-seven years), so long-term projects, stakeholder interests, and sustainability are easily eschewed in favor of steep cuts and speedy resale. This is especially true when private equity funds push for drastic changes in

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[26] *See* MOWERY & SHOENFELD, *supra* note 21.
[27] *Id.*
[28] Dan Primack, *Private Equity Can't Sell Companies, So It's Taking Debt Dividends*, AXIOS (June 18, 2024), https://www.axios.com/2024/06/18/private-equity-dividend-recaps [https://perma.cc/83SD-UE53].
[29] *Id.*
[30] *The Concept of Multiples Expansion: How [Most] Private Equity Works*, HILL VIEW PARTNERS, https://hillviewps.com/the-concept-of-multiples-expansion-how-most-private-equity-works/ [https://perma.cc/QH3A-QH2U] (last visited Feb. 4, 2026).
[31] *Id.*
[32] *Id.*
[33] *See* SCHRODERS, *supra* note 22.
[34] *See* Morran & Petty, *supra* note 12.
[35] *Id.*

small businesses that have operated for decades, throughout various business cycles and environments. Essentially, the new private equity boss may not grasp how or why the business has worked for so long. But if enough cost can be cut in a short enough period to quickly resell the business, no one will notice.

B. Private Equity and Healthcare

Private equity has steadily increased its deal flow in the healthcare space for nearly two decades.[36] Healthcare data refers to hospitals and smaller practices.[37] $115 billion was invested in healthcare by private equity funds in 2024, the second-largest single year of investment on record.[38] "Five [deals] exceeded $5 billion" alone, compared to three such deals combined in the prior two years.[39]

One would be forgiven for feeling uneasy about private equity's hunting of healthcare after reading the prior section outlining private equity's mission, tactics, and timelines.[40] A study conducted by physicians found an overall increase in "[h]ospital-acquired adverse events (or conditions)" at healthcare practices owned by private equity funds, despite a patient population lower in risk than the median.[41] Put simply, when private equity comes into a healthcare practice, the practice starts taking patients with simpler, less risky ailments and even still makes more mistakes than other practices. Put even more simply, private equity is ill-equipped to run efficient, patient-focused healthcare. However, private equity *is* well-equipped to make money in its healthcare investments. One study found that eight out of ten practice areas experienced increased prices for patients after private equity funds gained control of the practices.[42] Worse care, higher prices.

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[36] *Private Equity in Healthcare: Top Health Industry Issues*, PWC, https://web.archive.org/web/20190331192021/https://www.pwc.com/us/en/industries/health-industries/top-health-industry-issues/pe-in-healthcare.html [https://perma.cc/K5GZ-57VX] (last visited Feb 4, 2026).
[37] *See* Morran & Petty, *supra* note 12.
[38] *See* Jain et al., *supra* note 4.
[39] *Id.*
[40] Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*, AM. ANTITRUST INST. (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf [https://perma.cc/CYY7-HUEV].
[41] Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2365 (Dec. 26, 2023), https://jamanetwork.com/journals/jama/fullarticle/2813379 [https://perma.cc/YJ8G-V6ML].
[42] *See* Scheffler et al., *supra* note 40.

Decreased quality of care is not the only way private equity funds negatively impact the healthcare experience for patients.[43] A *ProPublica* investigation documented a hospital group's severe increase in lawsuits for nonpayment of medical bills to patients—in a six-month span, a single hospital sued its patients more than three neighboring hospitals sued their own patients combined.[44] The increase in lawsuits coincided with Blackstone—a large, well-known private equity fund—purchasing the hospital group for $6.1 billion dollars.[45] Patients, often low-income and managing chronic illnesses, were blindsided by the suits (it should be noted that the lawsuits came from entities the patients had never heard of).[46] The practice was curbed, not when government or state attorneys general intervened, but when the journalists behind the investigation asked for comment.[47] Surprise billing as a healthcare problem is not unique to private equity-owned practices, but private equity has taken on the burden of funding lobbying to resist legislative efforts to stop surprise billing.[48] Congress's efforts to prevent surprise bills, which often pop up after emergencies when patients are not able to determine whether care is in-network in real time, have been severely hamstrung by shadow lobbying efforts funded by private equity.[49] In the lead up to one bill in 2019, tuned to helping fix one of Americans' biggest issues with their healthcare experience, a lobbying group linked to private equity spent $28 million on ads opposing the bill.[50] If a patient receives care at a practice or hospital owned by private equity, that patient's provider is more likely to come after the patient for surprise bills, and will use some of its increased profits from such bills to lobby in opposition to potential laws curbing surprise medical bills.[51]

To delve a bit deeper into emergencies and exorbitant out-of-network patient fees, in 2016 the *New York Times* documented private equity funds'

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[43] Wendi C. Thomas et al., *This Doctor's Group Is Owned By a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them*, PROPUBLICA (Nov. 17, 2019), https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them [https://perma.cc/5EP9-J3B7].
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] Erin C. Fuse Brown, *Stalled Federal Efforts to End Surprise Billing–The Role of Private Equity*, 382 N. ENGL. J. MED. 1189, 1190 (2020).
[49] *Id.*
[50] *Id.*
[51] A 2020 law—the No Surprises Act—outlawed the most egregious forms of surprise billing, but workarounds have already taken hold. *See* Harris Meyer, *A Surprise Billing Law Loophole? Her Pregnancy Led to a Six-Figure Hospital Bill*, NPR (Feb. 28, 2023), https://www.npr.org/sections/health-shots/2023/02/28/1159786893/a-surprise-billing-law-loophole-her-pregnancy-led-to-a-six-figure-hospital-bill [https://perma.cc/2FHZ-BMUV].

investment in ambulance companies—and the corresponding drop in response times and depletion of supplies.[52] One company had nearly a third of its ambulances out of service, bedbugs in its dispatch center, and such depleted supplies that employees were restocking them with funds out of their own pockets.[53] Three of twelve ambulance companies owned by private equity funds in the investigation went bankrupt; while they each had issues that preceded private equity's ownership, no other ambulance companies went bankrupt during this period.[54] Emergencies necessitating ambulance rides force patients to accept charges and care levels as they come, without the opportunity to shop around or seek a second opinion, as other medical issues theoretically afford patients. But perhaps the only emergencies more nerve-wracking and more medically critical—thus forcing patients even further from a rational bargaining position—are emergencies that require air ambulance lifts.[55] Private equity has involved itself in these emergency carriers, too, and they still charge more; one study found that private equity-owned air ambulance companies charged nearly $20,000 more per ride than did otherwise owned companies in the same industry in 2017.[56] One important caveat here is that the otherwise owned companies charged 4.3 times as much as Medicaid would have paid; healthcare is expensive in America, without a doubt.[57] But private equity makes it more expensive, and at the most inopportune times; the study focused on two air ambulance companies that represent nearly two-thirds of the market in the Midwest, and whose patients were 80% out-of-network.[58] If an emergency befalls an individual, they might save significant money if they ask the 911 operator if the ambulance on its way is owned by a private equity fund. But, as the air ambulance industry in the Midwest shows, depending on where one is located, there may be no choice.

Another study examined the replacement rate of doctors for advanced practice providers at practices owned by private equity funds versus practices

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[52] Danielle Ivory, Ben Protess & Kitty Bennett, *When You Dial 911 and Wall Street Answers*, N.Y. TIMES (June 25, 2016), https://www.nytimes.com/2016/06/26/business/dealbook/when-you-dial-911-and-wall-street-answers.html [https://perma.cc/M55X-ZTNM].
[53] *Id.*
[54] *Id.*
[55] Loren Adler, Kathleen Hannick & Sobin Lee, *High Air Ambulance Charges Concentrated in Private Equity-Owned Carriers*, BROOKINGS (Oct. 13, 2020), https://www.brookings.edu/articles/high-air-ambulance-charges-concentrated-in-private-equity-owned-carriers/ [https://perma.cc/ZNN3-QGLE].
[56] *Id.*
[57] *Id.*
[58] *Id.*

owned otherwise.[59] The study revealed a statistically significant increase in private equity-owned practices replacing doctors with advanced practice providers.[60] "Advanced practice providers" refers to non-M.D. healthcare professionals who are licensed to practice medicine to some degree, like nurse practitioners and physician assistants.[61] In other words, medical professionals in white coats who did not attend medical school, but have the outward appearance of being medical doctors, particularly at first glance or to patients unfamiliar with the nomenclature.[62] While this group has been increasingly tapped to stand in for doctors across the healthcare industry—the group's rise in prominence is not solely the doing of private equity—it is not surprising that private equity is replacing doctors with lesser-paid medical professionals at a significantly higher rate than the industry at large.[63] The other way to read the data is that doctors are leaving private equity-owned practices at higher rates than practices owned otherwise.[64] Either way, when private equity funds buy practices or hospital groups, the chance that a patient will be seeing a doctor declines relative to other practices not owned by private equity.

C. Present Solutions to the Problem of Private Equity and Healthcare

The most popular answer to the problem of private equity in healthcare today is state-level attempts to enact "mini-HSR" laws regulating healthcare transactions in their respective states via antitrust mechanisms.[65] Analysis of these laws reveals that while only one state proposing such a law explicitly mentions private equity, most of the laws are written with private equity in mind (or at minimum, the industry consolidation in healthcare that private equity contributes to a large extent).[66] The laws, each different in language

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[59] Joseph Dov Bruch et al., *Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices*, 42 HEALTH AFFS. 121, 121 (2023), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00308 [https://perma.cc/MJ86-25B2].

[60] *Id.*

[61] Jake Miller, *Fourth of U.S. Health Visits Now Delivered by Non-Physicians*, HARV. MED. SCH. (Sep. 14, 2023), https://hms.harvard.edu/news/fourth-us-health-visits-now-delivered-non-physicians [https://perma.cc/G9YB-S5G7].

[62] *Id.* While this characterization sounds harsh, it is accurate and is based upon the confusion patients often feel when trying to navigate the maze of providers—M.D. or N.P. is just another thing to worry about getting right, like ensuring one is in-network. It should be noted that the rise in advanced practice providers in many fields can lower patient costs and advanced practice providers provide commensurate care with doctors. *Id.* There are some more technically advanced fields where an M.D. is considered essential, however. *Id.*

[63] *See* Bruch et al., *supra* note 59.

[64] *See id.*

[65] *See* Naranjo et al., *supra* note 7.

[66] *Id.*

and not seeming to be from a centralized effort, broadly seek to introduce a regulatory "holding period" for investment in healthcare in their respective states.[67] This regulatory framework is called a "mini-HSR" because it mirrors the regulatory review period for large acquisitions in the economy at large mandated by the federal Hart-Scott-Rodino Act.[68] Under the (big) HSR, the Federal Trade Commission (FTC) receives paperwork on large mergers and reviews in tandem with the Department of Justice (DOJ) for violations of federal antitrust law.[69] The proposed state laws mirror this type of review; at least giving state regulators time to understand and, potentially, reject deals that impede competition in their state's healthcare industry.[70] But the framework to reject deals appears unlikely to consider private equity involvement itself, rather only considering competition generally.[71] In addition to state legislatures' efforts, state attorneys general have requested more information from the federal government on industry consolidation in healthcare.[72] The attorneys general highlighted broad concerns that overlap with the previous parts of this section: private equity in healthcare leads to increased prices, diminished care, overleveraged balance sheets, risk-taking and loophole exploitation, and, intelligently, the risk that degraded medical practices are themselves more likely to be seen as ripe for acquisition by other private equity funds.[73] Notably, the attorneys general seem to come at the problem from the antitrust perspective, citing their role as enforcers of both federal and state antitrust law.[74]

Other enforcement mechanisms focus less on the structural impact of private equity controlling healthcare practices, but rather on the bad acts that private equity-owned practices are more likely to take part in, like surprise billing.[75] Federal laws now prohibit surprise billing in emergencies,[76] and

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[67] *Id.*
[68] *Premerger Notification and the Merger Review Process*, FED. TRADE COMM'N, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review-process [https://perma.cc/X3VA-WV5R] (last visited Feb. 4, 2026).
[69] *Id.*
[70] *See* Naranjo et al., *supra* note 7.
[71] *See id.*
[72] *Comments of Eleven Attorneys General in Response to the February 29, 2024 Request for Information on Consolidation in Healthcare Markets*, CAL. ATT'Y GEN. (June 5, 2024), https://oag.ca.gov/system/files/attachments/press-docs/Comments%20by%2011%20Attorneys%20General%20in%20Response%20to%20Feb.%2029%20RFI%20on%20Consolidation%20in%20Healthcare%20%281%29%5B2%5D.pdf [https://perma.cc/K77P-GDAA].
[73] *Id.*
[74] *Id.*
[75] Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527 (2024).
[76] *See* Meyer, *supra* note 51.

other laws prohibit self-referrals (another area where private equity "roll ups"[77] can lead to one fund owning both a practice and a supplier of the practice).[78] Two recent cases also illustrate the use (and potential limitations) of the False Claims Act by the federal government against private equity-owned healthcare providers.[79]

In *United States ex rel. Martino-Fleming v. South Bay Mental Health Center, Inc.*, a private equity-owned mental health services provider was sued for using unlicensed counselors without proper supervision and collecting from Massachusetts's Medicaid program.[80] In 2012, the private equity funds H.I.G. Capital and H.I.G. Growth[81] purchased South Bay, which ran seventeen mental healthcare facilities in Massachusetts.[82] A year later, in 2013, a whistleblower who worked at one of the facilities brought to light that most of the counselors were unlicensed, in many cases diagnosing patients while themselves only holding associates degrees.[83] This itself is not damning—but up to 75% of the supervisors were themselves unlicensed.[84] Around this time H.I.G., whose officers comprised the board of South Bay, commissioned a review of why their clinics had such high turnover.[85] The review led to revelations about the unlicensed status of the majority of counselors and their supervisors.[86] A hiring surge of supervisors with the appropriate licensure was recommended; the board declined, calling the review an "enormous waste of time."[87] The action followed, and the judge refused to dismiss the counts related to False Claims and False Statements Material to False Claims.[88]

This case serves to illustrate various issues with enforcement of private equity misconduct in healthcare via existing law. First, this action required a whistleblower to come forward, then the case to be picked up by the U.S.

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[77] John D. Wagner, *Roll-Up Acquisitions: How They Work*, LBM J (Oct. 27, 2021), https://www.lbmjournal.com/features/experts/john-d-wagner-mergers-acquisitions/article/15782099/roll-up-acquisitions-how-they-work [https://perma.cc/AG67-9TKH].
[78] *See* Brown & Hall, *supra* note 75, at 547.
[79] *Id.* at 553.
[80] United States *ex rel*. Martino-Fleming v. S. Bay Mental Health Ctr., Inc., No. 15-13065, 2018 WL 4539684, at *2 (D. Mass. Sep. 21, 2018).
[81] Tracking the names of entities involved in private equity deals is an ordeal; these entities may appropriately and practically be considered one and the same. Of note, legally they are not.
[82] *Martino-Fleming*, 2018 WL 4539684, at *4–5.
[83] *Id.* at *2–3.
[84] *Id.* at *8.
[85] *Id.* at *7.
[86] *Id.*
[87] *Id.* at *8–9.
[88] *Id.*

Attorney's and the Massachusetts Attorney General's offices.[89] Second, the action was based on conduct in 2013, but the order was released in 2018—it is unclear (and perhaps unlikely) that the violations persisted throughout this time, but it is relevant that it took so long for the court to get involved given the relatively short time frames in which private equity funds seek to flip their portfolio companies.[90] Third, this order refusing and granting dismissal of counts in the complaint was the last item in the case files, which implies a settlement.[91] While it is beyond the scope of this Note to comment on the efficacy of settlements in furthering justice (especially with very wealthy defendants), the egregious actions alleged in the complaint feel anticlimactically resolved if the solution was some sort of settlement with the government. Essentially, a settlement establishes a price to a violation, which could simply get baked in to the "cost of doing business" depending on the settlement amount and related litigation expenses.

United States ex rel. Carmen Medrano v. Diabetic Care RX, LLC is another case that used the False Claims Act against a private equity-owned healthcare company.[92] Here, private equity fund RLH purchased a compounding pharmacy, PCA in 2012.[93] The private equity fund explicitly identified a five year window to increase the pharmacy's profits and then exit (sell).[94] To accomplish this, RLH entered into a new business: the compounding of non-sterile topical creams.[95] The plan was to bill the federal government, with the profit margin expected to be 90%.[96] A convoluted scheme of pharmaceutical marketing allegedly followed.[97] The core of the scheme related to the pharmacy, under its parent private equity fund's direction, submitting "test claims" with the federal government to find the formula that would result in the most reimbursement (a calculation made based on various factors, including the cost of the materials).[98] The action followed, with some claims dismissed and others upheld.[99]

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[89] *Id.*
[90] *Id.* Remember that private equity funds target five-to-seven year holding periods for companies before attempting to sell; H.I.G. purchased South Bay in 2012 and this order came out six years later. *Id.*
[91] *See id.*
[92] United States *ex rel*. Carmen Medrano v. Diabetic Care RX, LLC, No. 15-CV-62617, 2018 WL 6978633 (S.D. Fla. Nov. 30, 2018*)*, *report and recommendation adopted in part sub nom.* United States *ex rel*. Medrano v. Diabetic Care RX, LLC, No. 15-CV-62617, 2019 WL 1054125 (S.D. Fla. Mar. 6, 2019).
[93] *Id.* at *3–4.
[94] *Id.*
[95] *Id.*
[96] *Id.* at *1–2.
[97] *Id.* at *3.
[98] *Id.* at *3–4.
[99] *Id.* at *15.

Again, this case illustrates similar issues as *South Bay* above: the time lag between alleged misconduct and judicial intervention, the variety of parties with claims, and suggestion of an ultimate settlement. Broadly, both cases show the challenges of litigating, bit by bit, misconduct by private equity owned healthcare companies when using existing law. Taken at face value, both adjudicated complaints alleged gross disregard for standards in medicine that are both expressly codified in law and naturally occur in the medical community. There must be a better way for governments to prevent private equity funds from degrading healthcare.

II. BACK TO THE FUTURE—CORPORATE PRACTICE OF MEDICINE LAWS

A. History of the CPOM Doctrine

Corporate Practice of Medicine (CPOM) laws are rooted in the common law and began the path to official codification in the nineteenth century.[100] Doctors, without the modern-day benefit of advanced education in microbiology, molecular chemistry, and other important scientific fields, were not widely trusted among the public—now-disclaimed medical actions like bloodletting were still commonly practiced.[101] To help remedy this, efforts were taken to create licensing bodies, and so the American Medical Association was established in 1847 after a national medical convention the prior year.[102] In the 1870s, further efforts were made to include the government in establishing legal standards for medical licensing.[103] And "[b]y 1905 all but three states required" doctors to both have a standardized degree and pass a state exam.[104]

At the core of CPOM laws is a desire to remove corporate profit motivation from the doctor-patient relationship.[105] CPOM laws were designed to facilitate patient trust—and the best possible care—by ensuring that only a patient's doctor had a say in what care she is to receive.[106] Essentially, CPOM laws prohibit non-licensed physicians from owning medical practices; there is to be no "man behind the curtain" urging one care plan over another for business reasons.[107]

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[100] *See* Chase-Lubitz, *supra* note 11, at 448–50.
[101] *Id.*
[102] *Id.*
[103] *Id.* at 451.
[104] *Id.*
[105] *See* Brown & Hall, *supra* note 75, at 525.
[106] *Id.* at 563.
[107] *Id.* at 563–64.

By the 1970s, however, progress in medicine and the national economy—leading to a bigger and more competitive medical economy—led to widespread criticism of the CPOM doctrine, which resulted in its characterization as being anti-competitive and stifling progress in medical science and care.[108] In fact, in the 1970s and 1980s, the FTC consistently and effectively argued that CPOM laws were so outdated to the current medical economy as to be legally anticompetitive.[109] But, despite the criticism and effective legal attacks by federal government regulatory bodies, CPOM laws have persisted in many states and remain on the books today, if in varying forms and with a range of teeth sharpness.[110]

B. Private Equity and CPOM

As one might imagine, private equity funds' entrance into the healthcare space has encountered existing state CPOM laws.[111] Despite a commonsense intuition that CPOM laws would outright bar private equity funds from purchasing medical practices, the funds have found workarounds.[112] The most common practice for subverting CPOM laws is the "friendly PC" model.[113] In this scheme, the private equity fund establishes a medical services organization—an MSO—and contracts with a professional corporation[114]—a PC.[115] The private equity-run MSO provides strictly business services to the physician-run PC; services like office space, supplies, and payroll support, for example.[116] The "friendly" piece comes from the MSO's separate relationship with the lead physician of the PC.[117] This separate relationship may include the physician's status as an employee of the MSO and/or contracts restricting the stock transfer of the PC by the physician without MSO approval.[118] This setup is legal and, when followed appropriately, allows private equity funds limited access to the business side of medical practices—if a private equity fund selects an up and coming physician to partner with and the physician expands operations, the private

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[108] *Id.*
[109] *Id.*
[110] *Id.* 565–66.
[111] *See* Crawford, *supra* note 9.
[112] *Id.* at 532.
[113] *Id.*
[114] A professional corporation is a statutorily accepted entity to run medical services from; consider it a form of an LLC. In fact, there are also PLLCs: professional limited liability companies. *What is a Professional Corporation or PLLC?*, WOLTERS KLUWER (June 29, 2022), https://www.wolterskluwer.com/en/expert-insights/what-is-a-professional-corporation-or-pllc [https://perma.cc/D4U5-7NW2].
[115] *See* Crawford, *supra* note 9, at 532.
[116] *Id.*
[117] *Id.* at 533.
[118] *Id.*

equity fund via its MSO would theoretically get more business from the expanded operations.[119] But sometimes these sorts of workarounds do not follow the letter of the law. California—a state with strong CPOM law—provides relevant application of state law[120] and caselaw to illustrate how these compromised statutory schemes may run awry.

C. Application of the CPOM Doctrine, Generally

1. California

In *Steinsmith v. Medical Board*, Dr. Steinsmith worked for a practice in California run by non-doctors with insufficient medical licensing.[121] Dr. Steinsmith became aware of the lack of medical licensing around the same time he became aware that California requires a licensed physician to run a practice.[122] Convinced of his lack of guilt in perpetuating the ills CPOM was designed to protect against—insistent that he alone exercised autonomy of patient care at the practice—Dr. Steinsmith kept up the status quo.[123] Dr. Steinsmith was cited and fined for aiding the unlicensed practice of medicine.[124]

The *Steinsmith* court walked through the doctrine of CPOM, its early application, and some contemporary exemptions to the doctrine.[125] Notably, the *Steinsmith* court found that CPOM was upheld as far back as the 1930s, when a non-dentist opened a corporation to run a dental practice and employ dentists.[126] And the *Steinsmith* court noted that at times CPOM has been restricted in its application, particularly when a county agreed with local medical schools to provide extra care for a needy low-income sick population.[127]

In *People ex rel. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C.*, the *Discovery* court affirmed and acknowledged the idea that sometimes "it is not always possible to divide" the medical practice itself, and the care required, from business concerns attended to by lay people.[128]

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[119] *Id.*
[120] *See* CAL. BUS. & PROF. CODE § 2000 (West). This expansive code section governing medical licensure in California contains various provisions cited in CPOM cases.
[121] Steinsmith v. Med. Bd., 102 Cal. Rptr. 2d 115, 116 (Cal. Ct. App. 2000).
[122] *Id.* at 117.
[123] *Id.*
[124] *Id.* at 116.
[125] *Id.* at 120.
[126] *Id.*
[127] *Id.*
[128] People *ex rel*. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C., 311 Cal. Rptr. 3d 901, 912 (Cal. App. 2023).

There, a non-doctor, Mir, was alleged to be intimately involved in referrals for radiology services.[129] Mir ran a company that marketed radiology services to accident victims through their attorneys, and would then refer his new patients to a variety of clinics ostensibly (on paper) led by physicians.[130] But Mir was himself too involved in the medical side of the practices to which he was referring patients.[131]

The core of the CPOM doctrine, as analyzed in depth by the court in *Allstate Ins. Co. v. Discovery Radiology Physicians, P.C.*, is to prevent a non-licensed person from exercising control over medical care at the practice level.[132] Here, the *Discovery* court specifically singled out Mir's control over referrals as enough to spring the CPOM doctrine in California.[133] Even though much of Mir's actions, including control of business-side operations, would have been legal, his foray into referrals was a bridge too far.[134] Notably, the court did not impose brightline rules in this case, but instead exercised a more fact-intensive inquiry into the nature of the relationship between the physicians and their (apparent) patients, as well as the non-physician's relationship with and control over the care to be provided.[135]

2. Texas

Another state with strong CPOM laws—in addition to California and New York—is Texas.[136] Texas courts have consistently applied CPOM doctrine to invalidate practices where licensed physicians act more as employees of non-physicians than independent medical practitioners. These cases demonstrate another core tenet of CPOM: doctors must not be mere employees of non-doctors.

In the first instance of Texas courts examining and validating their state's CPOM-based law, *Rockett v. Texas State Bd. of Medical Examiners*, Dr. Rockett worked for a practice owned by Mr. (not Dr.) Thomas.[137] Thomas owned the practice outright.[138] Dr. Rockett was paid a monthly salary, and

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[129] *Id.* at 905.
[130] *Id.* at 906–07.
[131] *Id.* at 916.
[132] *Id.* at 912.
[133] *Id.* at 916.
[134] *Id.*
[135] *Id.* at 916–17.
[136] *Health Care Regulatory Primer: Management Service Organizations*, CHAPMAN & CUTLER LLP (Oct. 12, 2017), https://www.chapman.com/publication-Health-Care-Management-Service-Organizations [https://perma.cc/4NW6-6WLB].
[137] Rockett v. Texas State Bd. of Med. Examiners, 287 S.W.2d 190, 191 (Tex. Civ. App. 1956).
[138] *Id.* at 191.

Thomas controlled the profits.[139] The trial court found the practice dissolvable on the facts found, and the appellate court affirmed the legal application.[140]

The Texas court, in affirming the jury's finding, took it upon itself to survey the CPOM doctrine nationwide.[141] After ticking off numerous other states with court decisions affirming the doctrine as state law, the Texas court emphasized the underlying, ultimate point of CPOM itself via borrowed analogy.[142] The Texas court cited to a decision regarding an arrangement, notably important to lawyers, where a corporation employed a lawyer to perform legal work.[143] The lawyer only received his salary, not his fees.[144] A Minnesota court invalidated this scheme, writing that:

> There can be no objection to the hiring of an attorney on an annual salary basis by banks, other corporations, firms, or individuals, to attend to and conduct its or their legal business. An attorney so employed may, as attorney for his employer, foreclose mortgages owned by such employer, and may include the proper attorney's fees therefor in the foreclosure charges, so long as such fees are covered by and paid to him out of his salary and do not exceed what is actually paid to him or result in any profit to the employer. But neither a corporation nor a layman, not admitted to practice, can practice law, nor indirectly practice law by hiring a licensed attorney to practice law for others for the benefit or profit of such hirer. For this bank to employ defendant to conduct law business generally for others, for the benefit and profit of the bank, amounted to the unlawful practice of law by the bank, and was misconduct both on the part of the bank and this defendant, who was a participant therein.[145]

The Texas court closed its opinion with this quoted section without explanation, likely because the analogy is self-evident. Just as a lawyer likely would be, and should be, offended at the notion that a corporation could direct legal work without itself holding a law degree, so too would doctors (and patients) be offended at non-doctors directing and controlling the care and profits from the practice of medicine. CPOM laws reflect this stance.

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[139] *Id.*
[140] *Id.* at 190.
[141] *Id.* at 191–93.
[142] *Id.* at 193.
[143] *Id.* at 192–93.
[144] *Id.*
[145] *Id.* (quoting *In re* Otterness, 232 N.W. 318, 319 (Minn. 1930)).

Texas courts have consistently relied on and expanded upon this case to develop a strong CPOM caselaw.[146]

D. Application of the CPOM Doctrine to MSOs: Two Approaches

The following two cases—*Flynn Bros.* and *Radiologix*—demonstrate dueling approaches when courts encounter an MSO (or like scheme) and must apply CPOM doctrine to decide if the arrangement is legal.[147] A distinction between the approaches—and their disparate outcomes—can be attributed to the sophistication of the contracts. In *Flynn Bros.*, the MSO was formed via oral agreement.[148] In *Radiologix*, the parties clearly used lawyers extensively in drafting and amending their contractual agreements.[149] But past the contract form, it is evident that the respective courts held different attitudes about the role they play in applying CPOM doctrine.

1. The Court Holds *Flynn Bros.* to the Fire

In *Flynn Bros.*, the Flynn brothers found out that a nearby hospital was looking to contract with an outside party to staff a department.[150] But the two brothers were not doctors, so they convinced a friend of theirs, Dr. Adcock, to join them in forming a corporation to bid on the chance to staff the department.[151] Once again, however, the brothers ran into a CPOM issue: they could not, in Texas, be part of a corporation that provided care if they were not doctors—one doctor among laymen was not sufficient, only doctors without any laymen would be allowed.[152] So the brothers had Dr. Adcock form a professional corporation, a "friendly PC," while the brothers formed a regular corporation and entered into a management agreement with the friendly PC.[153] After winning the contract to staff the hospital, the parties agreed to split the profits from the contract evenly (a third of the profits to each of the men).[154] When the relationship between the doctor and the

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[146] *See, e.g.*, Flynn Bros. v. First Med. Assocs., 715 S.W.2d 782, 785 (Tex. App. 1986); Watt v. Texas State Bd. of Med. Examiners, 303 S.W.2d 884, 887 (Tex. Civ. App. 1957); and McCoy v. FemPartners, Inc., 484 S.W.3d 201, 205 (Tex. App. 2015) (finding that CPOM was not triggered by agreement at issue, but tracking the caselaw through the previous more than half-century).
[147] *Flynn Bros.*, 715 S.W.2d at 783; Radiologix, Inc. v. Radiology & Nuclear Med., LLC, No. 15-4927, 2017 WL 5007143 (D. Kan. Nov. 2, 2017).
[148] *Flynn Bros.*, 715 S.W.2d at 782.
[149] *See Radiologix, Inc.*, 2017 WL 5007143.
[150] *See Flynn Bros.*, 715 S.W.2d at 783.
[151] *Id.*
[152] *Id.*
[153] *Id.*
[154] *Id.*

brothers frayed, they went to court.[155] The court was left to decide if the venture was valid under Texas CPOM law.[156]

The court ruled that the ventures were invalid because they were designed to, and in practice did, subvert CPOM law and its underlying philosophy.[157] The court discerned the intent of the agreement from the testimony of the parties and the chronology of the paper trail; the parties actually won the contract before being informed of the issues with their singular corporation before going on to create the friendly PC coupled with the MSO.[158] Most importantly, the court explicitly and purposefully looked past the technical form of the setup to its practical effect, writing that "[a]lthough it is true that Dr. Adcock was not an 'employee' of [the Flynn brothers] under their agreement, the practical effect was the same."[159] The court too noted that "[t]he design, effect, and purpose of the management agreement contravenes [CPOM doctrine enshrined in law] and therefore will not be enforced by the courts of this state."[160]

The approach here by the mid-1980s Texas state court illustrates an aggressive enforcement approach to CPOM. Texas, as noted above, is considered one of the three strongest CPOM states in the country (along with California and New York).[161] While it is tempting to see the contract status as an oral agreement as the defining issue, the court made sure to emphasize that it was reaching past form to the true nature of the agreement.[162] This is one approach for courts to dig into PC-MSO arrangements to test if they are valid under CPOM doctrine.

2. Contracts Rule in Kansas

Another, far more lenient approach was used by a late-2010s Kansas federal court in *Radiologix*.[163] There, in a similar scheme as in *Flynn Bros.*, a group of doctors formed a medical corporation and contracted with an MSO made up of non-doctors to provide services in exchange for a

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[155] *Id.* at 784.
[156] *Id.*
[157] *Id.* at 785.
[158] *Id.* at 783.
[159] *Id.* at 785.
[160] *Id.*
[161] *Navigating CPOM Laws Across States: Compliance Strategies for Healthcare Businesses*, ZIVIAN HEALTH (Dec. 8, 2024), https://zivianhealth.com/blog/navigating-cpom-laws-across-states-compliance-strategies-for-healthcare-businesses/ [https://perma.cc/456X-XQDL].
[162] *Flynn Bros.*, 715 S.W.2d at 785.
[163] Radiologix, Inc. v. Radiology & Nuclear Med., LLC, No. 15-4927, 2017 WL 5007143 (D. Kan. Nov. 2, 2017).

percentage of the practice's earnings.[164] Again, when the parties ran into legal issues over a potential sale, the agreement ended up in court to test for (among other things) its validity under CPOM.[165]

But here, unlike in *Flynn Bros.*, the court found that the agreement was valid.[166] Of note, the parties were (presumably) using sophisticated lawyers and every detail was recorded on paper, in sharp contrast to *Flynn Bros*.[167] More importantly, the court distinguished between the facts at hand and the facts in a Washington case, *Engst*, which the court found to be somewhat persuasive.[168] According to the Kansas court, the *Engst* court found a dental practice's MSO agreement invalid because the MSO was advising the practice, guaranteed some of the practice's debts, and tried to enforce the practice's employment agreements with its doctors.[169] Here, the *Radiologix* MSO was attempting to enforce the practice's employment agreements with its doctors as a third-party.[170] And the MSO was advising the practice through a board formed together between the doctors and non-doctors.[171] But the *Radiologix* court did not care, because the contracts expressly disclaimed that the MSO had hiring power and that the advisory board would only discuss management matters, not medical matters.[172]

These two different approaches display two different legal ways to enforce CPOM. Where the Texas court focused on the practical effect of the agreement, the Kansas court allowed the language of contracts to dominate its analysis. In the MSO context of CPOM, this is a core distinction. And while it could be explained as a product of the evolution of corporate law, CPOM was founded on the idea that corporate doctrine and medicine should not mix.

III. TAILORING CPOM

This Note proceeded in its first two parts by outlining what private equity is and why it disrupts efficient healthcare, then analyzed the CPOM doctrine as it currently stands. The final part will recommend updates to the doctrine. The first section established that private equity funds' goals and practices are

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[164] *Id.* at *3; *see Flynn Bros.*, 715 S.W.2d at 783.
[165] *Radiologix, Inc.*, 2017 WL 5007143, at *30–31.
[166] *See id.*; *Flynn Bros.*, 715 S.W.2d at 785.
[167] *Radiologix, Inc.*, 2017 WL 5007143; *Flynn Bros.*, 715 S.W.2d at 785.
[168] *See* Engst v. OrthAlliance, Inc., No. C01-1469C, 2004 WL 7092226 (W.D. Wash. Mar. 1, 2004); *Radiologix*, 2017 WL 5007143, at *31.
[169] *Radiologix*, 2017 WL 5007143, at *31.
[170] *Id.*
[171] *Id.* at *33.
[172] *Id.* at *32–35.

incongruous with the underlying public policy goals for healthcare in America. *Discovery* shows the issues with allowing some form of corporate control over healthcare via bypasses to the CPOM doctrine—the potential to muddy the water, and only clear it up via expensive private litigation, often undertaken by large insurance companies motivated by the desire to get out of paying claims.[173] Is CPOM, a relic echoing from bygone eras of bloodletting, up to the task of regulating modern healthcare and its embrace by private equity? And if it is, how should courts choose to enforce in an era of increasing complex contracts designed to wiggle through CPOM laws?

A. Criticism of CPOM

As touched on above, criticism of CPOM peaked in the 1970s and 1980s, at a time when medicine was modernizing rapidly and standard corporate practices were seen as requirements to ensure that innovation would not be stifled.[174] CPOM was called "suppressing," "puzzling," and "astounding."[175] At key moments when medicine needed to modernize to meet increasing medical science advancements, CPOM stood in its way.[176] Particularly, the doctrine's potential limitations in a pandemic event are viewed as strong enough considerations to abolish it—during the COVID-19 pandemic, full corporate involvement amidst the urgency was somewhat slowed down by CPOM requirements.[177] But critics of CPOM, in acknowledging the need for government intervention when non-physicians dictate care too strongly, reveal that at its core, while perhaps not conducive to unbridled capitalism in medicine, CPOM is still a good doctrine.[178]

B. Adapting CPOM

Clarity about the context of the recommendations to come is necessary, too. Seventeen states do not have CPOM laws.[179] And of the thirty-three states with CPOM laws, many states do not actively and vigorously enforce

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[173] See People *ex rel*. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C., 311 Cal. Rptr. 3d 901, 912 (Cal. App. 2023).
[174] *See* Mark A Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988).
[175] *Id.* at 510.
[176] *Id.* at 511.
[177] Kathrine Marous, *The Corporate Practice of Medicine Doctrine: An Anchor Holding America Back in the Modern and Evolving Healthcare Marketplace*, 70 DEPAUL L. REV. 157, 184–85 (2020).
[178] *Id.* at 177.
[179] Preethi Subbiah & Richard M. Scheffler, *When Does Private Equity Ownership of Physician Practices Violate "First, Do No Harm"?*, 27 AMA J. ETHICS 376, 377 (2025).

their existing laws.[180] Indeed, some have argued that one of the main ways CPOM can be improved is if states themselves simply enforce it more often.[181] Notably, Oregon has recently amended its law to allow for exactly this enforcement.[182] Particularly in the context of MSO agreements, courts can and should look closer at the relationship between the MSO and the lead physician, and critically ask if the physician is exercising sole control over care-based decisions, as the court did in *Discovery*.[183]

1. Consider Adding CPOM to Existing Enforcement

Stronger enforcement of CPOM laws could work in tandem with states' recent efforts to enact mini-HSR laws about healthcare. Antitrust regulation limits the scope of enforcement to monopolistic endeavors.[184] To be clear, private equity roll ups—purchasing all of either vertical competition or horizontal (supplier) competition in a given region—are a problem bigger than healthcare, affecting every sort of business private equity is interested in.[185] It may be tracked and prohibited by these proposed mini-HSR laws, which really only seek to more stringently apply existing law at a smaller level than the FTC is capable of managing entirely itself. CPOM laws, when reprioritized as good law with teeth, could also be applied in the mini-HSR review period for healthcare transactions. States allowing MSO agreements would be able to require and review strict guidelines for the CPOM doctrine, with states' attorneys general checking in, and empower the courts to intervene quickly. Particularly, there should be clear plans to prevent corporate entities—or anyone who is not a licensed physician—from exercising any control over patient care, as well as clear check in points

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[180] *See* Crawford, *supra* note 9, at 544; Matt Wilmot, Wes Scott & Ethan Rosenfeld, *Corporate Practice of Medicine Doctrine: Increased Enforcement on the Horizon?*, NELSON MULLINS (Jan. 17, 2023), https://www.nelsonmullins.com/insights/blogs/healthcare_essentials/enforcement/corporate-practice-of-medicine-doctrine-increased-enforcement-on-the-horizon, [https://perma.cc/4E38-XUBR].

[181] *See* Brown & Hall, *supra* note 75, at 592–93.

[182] Or. SB 951, 83rd Leg. Assemb., Reg. Sess. (2025), https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB951/Introduced [https://perma.cc/BA5R-ZYFD]; and Sabrina M. Punia, *Oregon Passes Strictest Corporate Practice of Medicine Law in the Nation*, MAYNARDNEXSEN (June 23, 2025), https://www.maynardnexsen.com/publication-oregon-passes-strictest-corporate-practice-of-medicine-law-in-the-nation [https://perma.cc/AMZ4-5ZNL].

[183] *See* People *ex rel*. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C., 311 Cal. Rptr. 3d 901, 916 (Cal. App. 2023).

[184] *See* Wash. Rev. Code §§ 19.420.010–.050 (2025) (Uniform Antitrust Premerger Notification Act).

[185] Press Release, Fed. Trade Comm'n, FTC and DOJ Seek Info on Serial Acquisitions, Roll-Up Strategies Across U.S. Economy, (May 23, 2024) https://downloads.regulations.gov/FTC-2024-0028-0001/content.pdf [https://perma.cc/7ADG-9P5B].

throughout the MSO-PC's relationship to ensure that the plans ensuring this separation of power are being followed. Additionally, any deviation from the agreed to plan should be litigated, with a disbandment of the MSO-PC agreement as one of the consequences.

One may wonder if strictly analyzing MSO-PC agreements to ensure that private equity funds can only be in the business of providing medical office supplies to practices will successfully deter private equity investment in businesses with such agreements. That is, partially, the point. As illustrated earlier, private equity's involvement in healthcare too often leads to increased prices, surprise bills, worse care, and, generally, an even furthering of the opaque nature of American healthcare. Should private equity seek to honestly invest in office supplies for doctors' practices, that is no issue. The issues arise when non-physicians start to exercise control over care and regulatory schemes by the state are ignored and demeaned.

Private equity has lost the benefit of the doubt when it comes to faithfully adhering to the principles of medical ethics. States need to recognize this. Folding strong CPOM enforcement into existing regulation and more modern antitrust regulatory efforts would be a strong start to ensuring patient care is prioritized.

2. Using *Flynn Bros.* to See Through Contracts

But beyond simply enacting and enforcing CPOM laws where states have not previously done so, and beyond closer scrutiny, it is important to establish the framework by which states will enforce their CPOM laws, particularly in the increasingly prevalent MSO context that private equity has shown an appetite to use to enter the business of medicine.

Courts should analyze MSO agreements with friendly PCs as the *Flynn Bros.*[186] court did, rather than as the *Radiologix* court did.[187] This means that MSOs cannot escape scrutiny of the practical effect of their relationship with the practice by contracting out of it. This is particularly important in the context of private equity funds buying MSOs because hiring good contract lawyers is a small price to pay for private equity funds if it means they can escape CPOM enforcement.[188] The *Flynn Bros.* facts may, serendipitously, have provided a model for courts to follow: imagine no contract exists.[189]

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[186] *See* Flynn Bros. v. First Med. Assocs., 715 S.W.2d 782 (Tex. App. 1986).
[187] *See* Radiologix, Inc. v. Radiology & Nuclear Med., LLC, No. 15-4927, 2017 WL 5007143 (D. Kan. Nov. 2, 2017).
[188] Perhaps one cost that private equity funds will not skimp on.
[189] *See Flynn Bros.*, 715 S.W.2d at 782.

Because the Flynn brothers did not write anything down, the court had to get to the core of the arrangement.[190] Other courts, in looking to enforce CPOM, should take a similar approach and firmly prioritize the effect of agreements over their wording. This approach forecloses the ability of sophisticated actors to contract around and through CPOM and keeps the spirit of the doctrine ahead of its letter. It would allow courts more leeway to determine who is directing critical care-related decisions, unshackling them from the supremacy of contracts. This way forward could complicate previously straightforward issues that otherwise could be resolved on the court's receipt of the relevant contracts. But a complicated problem should not—and has not before—deterred courts from the hard task of getting to the truth of a matter.

CONCLUSION

At a certain point, states need to make a hard decision between medicine and capitalism, two distinct pillars of the historical (and current) American claim to excellence that too often diverge in their ideal outcomes. Compromise will not suffice in all cases. In the instance of MSO agreements by private equity funds to subvert CPOM laws, states should strictly enforce the wall between medicine and office business with fact-based inquiries and disband schemes that suggest any control over patient care by non-physicians. Courts should follow the *Flynn Bros.* approach, in which contract language yields to reality.[191] The choice between good medicine and unbridled capitalism should be good medicine. Private equity and other corporate entities have a place in medicine and by many accounts do facilitate the increased development of better care. But when it comes to care decisions and the doctor-patient relationship, pure capitalism and corporate law doctrine cannot be the priority. If such a hard decision is made by states, then Americans' dismal view of their own healthcare experience may start to change for the better.

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[190] *Id.*
[191] *See id.*