

HEALTH LAW WEEKLY

October 16, 2026

New Developments in California's Corporate Practice of Medicine Law Raises Compliance and Litigation Considerations for Payers and Providers Alike

Joshua M. Robbins, Crowell & Moring LLP

Private equity's rapid consolidation of medical practices has drawn increased scrutiny from regulators, legislators, and payers, prompting questions about its effects on pricing, billing practices, and clinical independence. State laws banning the Corporate Practice of Medicine (CPOM) have long restricted non-medical professionals from controlling licensed providers. But until recently, enforcement of these rules focused mainly on regulatory oversight and physician licensing discipline, with private civil litigation based on CPOM theories remaining uncommon.

California has recently implemented one of the nation's first comprehensive statutes addressing private equity and hedge fund involvement in medical practice operations—including express prohibitions on non-physician control over coding, billing, and payer contracting. California Attorney General Rob Bonta, meanwhile, has been actively enforcing the new law both through enforcement actions and amicus advocacy. These new developments, in the wake of the decisions in *Emergency Medicine Physician Group v. Envision Healthcare* (2022) and *People ex rel. Allstate v. Discovery Radiology* (2023), mark a fundamental shift: CPOM compliance has taken on heightened significance for providers and private equity- or hedge fund-owned management companies, while payers may view these developments as strengthening potential theories for private enforcement.

Oregon has enacted similar legislation, and several additional states—including Washington, Massachusetts, Connecticut, and Illinois—have introduced or are considering comparable measures. More recently, several members of Congress introduced a bill that would more broadly ban the corporate practice of medicine at a federal level. This article focuses on California's new legal landscape, which may influence further legislation and enforcement in other jurisdictions.

Background on CPOM

CPOM laws generally prohibit non-physicians—including corporations and private equity investors—from employing physicians or controlling their professional medical judgment. The doctrine exists to prevent financial interests from compromising clinical

independence and to ensure physicians answer to patients and professional standards, not corporate profit motives.

In California, CPOM restrictions were long based on Business and Professions Code Sections 2400 and 2052, which prohibit unlicensed practice of medicine and corporate employment of physicians. The California Medical Board has issued guidance documents elaborating on these statutory provisions, identifying factors that may indicate impermissible corporate control—including non-physician involvement in clinical decision making, physician compensation structures, and governance arrangements. But before recent legislative developments, these guidelines were largely enforced through licensing discipline rather than private civil litigation.

To navigate CPOM restrictions while maintaining operational and financial control, corporations and private equity firms typically deploy a two-entity structure: a physician-owned professional corporation (the “friendly PC”) holds the medical license and bills payers, while a private equity or corporate owned management services organization (MSO) provides administrative support under a management services agreement. In a properly structured arrangement, physicians retain all medical decision-making authority, and the MSO merely handles back-office functions. But in practice, the line between permissible administrative services and impermissible control can potentially be breached.

Recent Legal Developments Affecting CPOM Enforcement

Several significant developments in California have reshaped the CPOM enforcement landscape, with implications for both payers and providers: the *Envision Healthcare* and *Discovery Radiology* decisions and the enactment of SB 351.

In 2022’s *Envision Healthcare* decision, a San Francisco federal court denied a private equity-owned company’s motion to dismiss a competitor’s lawsuit against it for unfair competition, based on allegations of violating existing CPOM laws by effectively controlling physician groups. While the defendant argued that CPOM rules could only be enforced by the Medical Board of California, rather than in private litigation, the court disagreed. Indeed, the court found not only that existing case law and guidance documents gave it enough basis to apply CPOM restrictions to the private equity-provider relationship, but that the court was arguably even better equipped to do so.

California’s 2023 *People ex rel. Allstate v. Discovery Radiology* decision was perhaps even more significant for private CPOM enforcement. In that case, an insurer sued several medical corporations providing radiology services, along with a non-physician the insurer claimed was controlling the providers in violation of the CPOM laws. The claim was based on California’s Insurance Frauds Prevention Act (IFPA) and asserted that all the claims the providers had sent to the insurer (and other payers) were fraudulent, even if the radiology services were performed and medically necessary.

While the trial court dismissed the claims, the California Court of Appeal reversed, finding that if the providers were acting in violation of the CPOM rules, their submission of claims in itself could amount to “structural fraud” that made the claims unlawful.

More recently, the legislature entered the arena. Effective January 1, 2026, California’s SB 351 applies broadly to any “management company”—defined to include private equity firms, hedge funds, and other entities that provide management or administrative services to physician practices—not merely traditional MSOs. And it significantly strengthens the state’s CPOM framework, in several respects.

First, SB 351 codifies many of the Medical Board’s prior guidance on CPOM compliance into statute, providing even further reference and support for courts when interpreting and enforcing restrictions. Second, rather than following the Board’s approach of listing certain types of conduct—such as controlling the hiring and firing of clinical methods—as “factors” to be considered in an overall determination of CPOM compliance, SB 351 makes such conduct independently unlawful. Thus, a private equity owner that engages in those practices could be found in violation of the law without considering any other conduct or factors. Third, the new statute adds new prohibitions on non-professionals exerting control over billing and coding, as well as requiring physicians to sign non-compete and non-disparagement agreements in most circumstances. Fourth, the law grants the California Attorney General express enforcement authority and establishes civil penalties of up to \$15,000 per violation.

Attorney General Bonta wasted no time putting the new law to use. In March 2026, he filed an amicus brief in a case pending before a California appellate court, which concerned whether an agreement between a private equity-backed MSO and a physician-owned professional corporation gave too much control to the former, in violation of CPOM laws. In May, the AG filed and settled a lawsuit against the private equity-owned company Aspen Dental Management, Inc. that allegedly violated SB 351 by excessively controlling dental practices. And in June, the AG brought and settled another such case against Carbon Health Technologies, concerning its agreements with “captive” PCs.

Similar legislation has been enacted in Oregon and introduced in Washington, Massachusetts, Connecticut, and Illinois. Meanwhile, at the federal level, there have been additional proposed rules enhancing ownership disclosure and review of management company acquisitions. This legislative momentum signals broad political concern and could make courts more receptive to enforcement theories.

Potential Expansion of Private CPOM-Related Litigation

The *Envision* and *Discovery Radiology* decisions, SB 351, and the recent Attorney General actions together have significantly altered the CPOM enforcement landscape in California, with potential implications for both payers seeking to challenge billing

practices and providers seeking to ensure compliance. The risk of government enforcement—particularly via civil enforcement actions by the AG—has obviously come into focus and could conceivably involved an increased interest in criminal cases under preexisting statutes.

But another potential development that has received less attention is private CPOM enforcement. While *Discovery Radiology* specifically involved claims under IFPA, payers or others may invoke its reasoning in connection with other theories of recovery. The court’s conclusion that claims submitted by unlawfully controlled entities are inherently fraudulent—regardless of whether services were rendered—could potentially be invoked in cases involving other types of liability theories, such as common law fraud, unjust enrichment, unfair competition, or even RICO.

The enactment of SB 351 may affect such claims by providing a more explicit statutory basis for CPOM requirements. Before SB 351, payers asserting CPOM violations often had to rely on the general terms of Business and Professions Code Sections 2400 and 2052 and extra-statutory Medical Board guidelines. SB 351’s express enumeration of prohibited conduct—including interference with coding and billing procedures—arguably provides clearer statutory predicates for claims that billing misconduct resulted from improper non-physician control.

Under certain litigation theories, liability could potentially extend beyond the billing providers to MSOs, private equity firms, or other entities exercising control, depending on the facts and the applicable legal standards. The extent to which such upstream liability theories will be recognized by courts remains to be determined.

At the same time, there may be a number of challenges and defenses to such private CPOM claims. In *Aoki Diabetes Research Institute v. Blue Shield of California Life & Health Insurance Co.* (2008), the court held that insurers could not invoke the CPOM laws to argue that their provider contracts were illegal and unenforceable and thereby escape payment obligations under those contracts. The subsequent *Discovery Radiology* decision distinguished *Aoki* because it involved statutory fraud claims, rather than contract defenses. Whether that later case and SB 351 will abrogate *Aoki* or extend liability in fraud cases will likely be the subject of further litigation.

As to RICO, fraud, and other affirmative claims based on CPOM allegations, defendants will likely raise defenses concerning standing, reliance, materiality, and other key elements. These issues, too, will need to be worked out in future cases.

Practical Considerations for Providers, Private Equity Firms, and Payers

In light of the evolving CPOM enforcement landscape, payers, providers, and private equity sponsors may want to take into account potential responses to the increased emphasis on CPOM compliance:

- **Credentialing and Contracting:** Payers may consider incorporating CPOM-related provisions into credentialing and contracting processes, including ownership and control disclosures, compliance representations, and audit rights. Clear contractual terms addressing CPOM compliance can help establish expectations and reduce the risk of disputes. Outside of network agreements, payers may also add more detailed discussions of CPOM compliance to their provider manuals and potentially incorporate them into claims submission procedures.
- **Identifying Compliance Concerns:** When reviewing provider arrangements, both payers and providers should be aware of structural features that may raise CPOM concerns, including governance provisions, economic terms such as management fees, operational controls over staffing and scheduling, billing arrangements, and any provisions that may affect clinical decision making.
- **Monitoring and Transparency:** Payers may use publicly available information—including transaction filings, ownership disclosures, and licensing records—as well as billing analytics to monitor for changes in utilization and coding patterns that may warrant further inquiry.

Conclusion

The confluence of California's new legislation addressing private equity involvement in medical practice operations, the *Envision* and *Discovery Radiology* decisions recognizing private enforcement and structural fraud theories, and growing legislative interest in consolidation oversight has heightened the significance of CPOM compliance for all stakeholders. What was once largely theoretical—private litigation based on CPOM violations—is increasingly becoming a practical reality in California, with similar developments possible in other states that adopt comparable legislation. Entities on both sides of the issue should respond by more closely reviewing CPOM compliance in provider operations and preparing for an increase in related litigation. Payers, providers, and PE sponsors alike should closely review CPOM compliance in their operations and prepare for an evolving compliance and litigation landscape.

About the Author

Joshua M. Robbins is a first-chair trial lawyer and former federal prosecutor who focuses on cases involving fraud, unlawful competition, and other misconduct, primarily in the health care and life sciences industries. He has been lead counsel in dozens of

Copyright 2026, American Health Law Association, Washington, DC. Reprint permission granted.

jury trial, bench trials, and arbitrations, acting for both plaintiffs and defendants, and has testified as an expert witness on anti-kickback law issues. As an Assistant U.S. Attorney, he led one of the largest health care fraud investigations in California history.