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

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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 monitor deals after the transaction has occurred.
- Strengthen state prohibitions against the corporate practice of medicine by preventing corporate investors from using MSOs to gain functional ownership or control over medical practices.

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 transactions, and close CPOM loopholes that permit corporate control over medical practices.

INTRODUCTION

Management service organizations (MSOs) have come to play a prominent role in the health care sector, fulfilling a range of administrative, operational, and management functions for medical practices. An MSO is an entity that provides non-clinical services — such as billing, human resources, payer contracting, and information technology support — to physician practices and other health care providers. By outsourcing these functions to MSOs, medical groups can focus on patient care

while benefiting from economies of scale, operational efficiencies, and professional management expertise. While MSOs offer important support services in today's complex practice environment, they also raise concerns related to corporate consolidation, clinical autonomy, and compliance with state bans on the corporate practice of medicine (CPOM). Indeed, MSOs today are the primary vehicle through which lay corporations acquire control over medical practices and are central to the meteoric rise of private equity (PE) and other corporate investments in physician practices in recent years.

Today's MSOs can be traced back to the model of physician practice management companies (PPMCs), which emerged in the 1990s to help practices manage rising administrative and financial pressures.[1] As managed care insurers exerted price pressure on providers and pushed them into risk-sharing reimbursement models, PPMCs sought to consolidate physician practices, offering greater market leverage and operational support. While initially successful, many PPMCs collapsed by the late 1990s due to overexpansion, unrealistic revenue expectations, and declining physician productivity.[2]

In recent years, MSOs have re-emerged. This time, they have new sources of capital, primarily PE and larger corporate entities such as insurance conglomerates, retailers, pharmacies, and drug wholesalers. As with PPMCs, today's MSOs facilitate corporate investment in medical practices either using full ownership or through contractual control (to navigate CPOM restrictions).[2,3] This model, explained in depth below, raises new questions about financial incentives, patient outcomes, and physician autonomy.

This policy brief focuses specifically on corporate MSOs — entities backed by investors, PE firms, or health care corporations — rather than physician-led MSOs, independent practice associations, or other physician-driven models. It also discusses the various functions and organizational structures of corporate MSOs, explores their potential benefits and risks, and offers a menu of policy options to regulate them at the state level.

What are Corporate Practice of Medicine (CPOM) Laws?

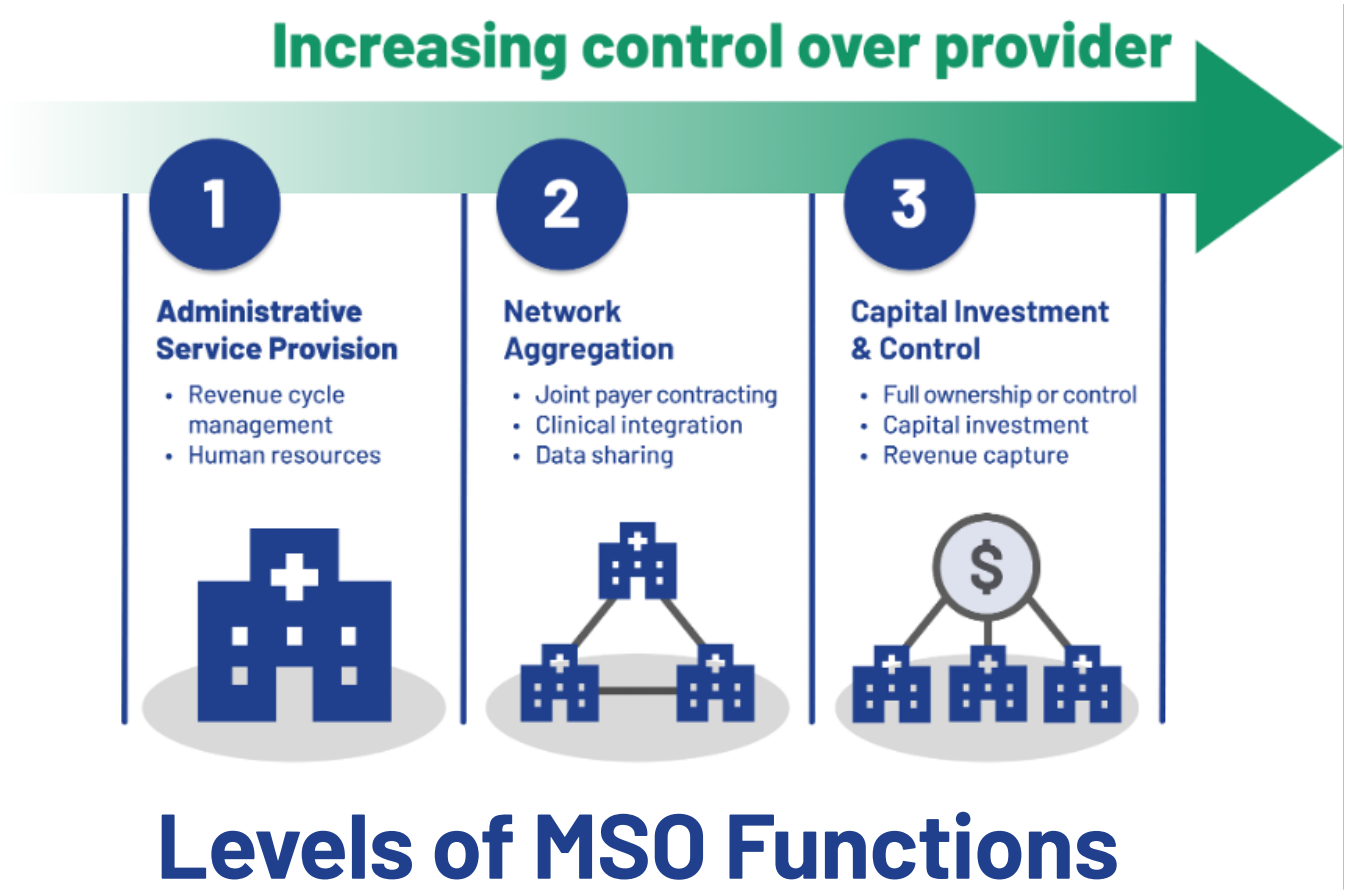
CPOM laws are state-level regulations that work to prohibit unlicensed lay-corporations from owning or controlling medical practices, or employing physicians. Stemming from the prohibition on the unlicensed practice of medicine, these laws aim to preserve the independent medical judgment of physicians and prevent undue corporate influence on patient care.[4]

The enforcement and interpretation of these laws varies across states. Most states allow exceptions, such as permitting professional medical corporations (owned by licensed physicians) or certain health care entities (like hospitals or managed care plans) to employ physicians. All states, however, permit the use of legal workarounds — like MSOs or friendly physician owner models (as described in this brief) to invest in and manage medical practices, even sometimes exerting control, without outright ownership.[5]

CORE FUNCTIONS OF MSOS

MSOs can fulfill three broad functions for medical practices: administrative services, network aggregation, and corporate ownership and investment. Traditional, more limited MSOs focus on discrete service provision and operate as ancillary vendors for medical practices. In contrast, other MSOs acquire medical practices, assume control of administration and management, and aggregate numerous practices to build regional density. As MSOs assume more functions of the medical practice, they advance along a continuum of control (Figure 1), raising important considerations around clinical autonomy, market power, and compliance with state CPOM laws.

Figure 1. MSO Continuum of Control of Medical Practice Functions



A. Administrative Service Provision

A long-standing function of MSOs has been to provide administrative functions to medical practices. These services may include billing and collection, coding, claims submissions, financial management, and analytic capabilities, often referred to as revenue cycle management. In addition, MSOs can provide human resources, payroll, patient and personnel scheduling, purchasing, and other practice management services. For instance, MSOs often bundle these services to physician practices, focusing on back-office functions to support the financial performance of the practices. Moreover, as quality metrics have become integral to payer contracts, these MSOs may also assist with tracking, performing, and reporting on such metrics and supplying practices with administrators to support practice management.[6,7]

While some MSOs focus solely on these discrete administrative functions, others take a more integrated approach, becoming deeply involved in the management and operations of the practices they support. MSOs with this level of involvement may handle responsibilities such as hiring and firing employees, recruiting clinicians, credentialing, and advertising. In such cases, MSOs not only provide operational support but may assume increasing control over the practice's overall governance and decision-making, particularly as they combine the administrative functions with the two functions described below.

B. Network Aggregation

Many MSOs aggregate individual practices and independent practitioners into larger provider networks for the purposes of contracting with payers. By aggregating practices, MSOs increase their bargaining power with payers while enabling care coordination, data sharing, bulk purchasing, and risk sharing. MSOs can achieve this network aggregation via "soft consolidation," where practices remain independent but enter into contractual agreements that allow them to act as a unified entity for payer negotiations. Certain legal entities, such as clinically integrated networks and accountable care organizations (ACOs), explicitly allow otherwise independent

providers to engage in joint payer contracting without violating antitrust laws that prohibit price fixing.[8] The resurgence of risk-based reimbursement models, in the form of Medicare Advantage and ACOs, has spawned significant corporate investment in MSOs focused on aggregation. As in the 1990s, these PE- and corporate-backed MSOs can help practices in need of scale and capital to succeed under risk-based payment models.[9]

As a network aggregator, the MSO may assume a range of control over participating practices. Companies like Aledade and Pearl Health, for example, are investor-backed MSOs that primarily aggregate practices into ACOs, supplying them with technology and operational guidance exercising more moderate influence over operations in the practice.[10-13] Privia, as another example, originally operated in the same mold but has expanded to a more capital-intensive and more controlling model, in which it acquires the physical assets of a practice and fully assumes operational functions. This model effectively combines aggregation with administrative services and de facto corporate ownership, which is discussed more below.

C. Capital Investment and Control

Some MSOs enable corporations to control and invest capital into practices. These entities are the most involved and controlling form of MSOs. This model is most associated with PE "roll-up" acquisitions and other corporate acquisitions of medical practices, such as by insurance conglomerates (e.g., UnitedHealth and Humana),[14,15] drug wholesalers (e.g., McKesson),[16] and retailers (e.g., Walgreens and Amazon).[17,18] In its most extreme form, the PE or corporate entity that supplies capital will use the MSO merely as a corporate vehicle to buy out the shares of the medical practice and assume de facto ownership of the medical practice by installing a "friendly" or "captive" physician owner of the practice. This enables the MSO to functionally assume ownership while complying with — or, as some observers argue, evading — state bans on CPOM.[19,20] Large publicly traded and PE-backed providers use this model to functionally acquire and run medical practices.

Alternatively, the MSO may follow a joint-ownership model with practices, supplying capital and assuming some but not all management functions. This model is sometimes used in PE roll-ups. There, MSOs acquire and merge smaller independent practices into a large MSO-run platform practice. The MSO provides capital to fund the acquisitions and technological needs (e.g., electronic health records or data infrastructure), and may or may not control practice revenues and assets. While sometimes using the friendly physician owner model, MSOs may instead partner with a set of platform practices in a more lateral relationship. This, for example, is common with PE-backed orthopedic groups such as U.S. Orthopaedic Partners and United Musculoskeletal Partners. In such cases, the physician owners are often granted minority shares in the MSO. Despite this shared ownership, the MSO typically ensures significant control through contractual mechanisms, such as stock transfer restriction agreements,[19,21] which limits the autonomy of the remaining physician owners.

Why MSOs Are Attractive to Physicians

Numerous factors draw physicians to MSOs. Today, in a sea change from decades prior, nearly 80% of physicians are now employed or affiliated with hospitals, health systems, or corporate entities.[24] The latest statistics reflect the specific rise of MSOs: non-hospital corporate owners, such as PE firms and insurers, now surpass hospitals and health systems in ownership of physician practices (30.1% vs. 28.4%), although hospitals still continue to employ more physicians.[24] Optum alone is reported to employ or affiliate with 10% of physicians, using the MSO as a corporate vehicle to do so.[25] For some physicians, corporate investment and ownership brings the promise of operational support in a difficult practice environment. In addition to managing rising administrative burdens, MSOs can help with health information technology and the transition to value-based payment models.[26-29] For others, these investors offer a lucrative co-investment opportunity or golden parachute as they retire. The ability of large corporate-backed MSOs to aggregate practices under these entities can enhance their negotiating power, enabling them to secure higher reimbursement rates from insurers, resulting in increased compensation for physicians.[30,31] MSOs also often offer equity stakes, allowing physicians to benefit from the future growth of the organization, as well as structured payouts that provide long-term financial stability.[32,33]

As described above, capital investment often alters the ownership or control of practices, centralizing governance and operational decision-making. These MSOs are designed to achieve maximum scalability and control, often consolidating the markets for these services both within and across geographic regions.[22,23] Given the heightened levels of control, these MSOs also likely perform the administrative (human resources, revenue cycle management, purchasing) and network aggregation (payer contracting, value-based payment management) functions described above, while also supplying the capital to consolidate and assume total control over the practices.

THE POTENTIAL RISKS OF MSOS

While the direct impacts of MSOs have not yet been extensively studied, insights from broader trends in health care consolidation provide valuable context, given the significant role MSOs play as an intermediary in facilitating these changes.

A. Consolidation and Costs

Consolidation Trends. MSOs can play a pivotal role in facilitating stealth consolidation, enabling PE firms, insurers, and other corporate investors to combine fragmented physician practices to increase market power to negotiate higher payment rates with insurers. Markets that are most attractive for PE entry often have a large practice or specialty clinic available for acquisition — a "platform company" — and multiple additional "add-on" practices that can be acquired to grow the PE firm's control over the market. Once a PE firm consolidates these firms, it benefits from economies of scale and negotiating power through its larger market share. This often results in price increases across care settings, as evidenced by allegations against Team Health, an MSO accused of price-fixing, upcoding, and fraud.[34] PE firms have led to significant physician market consolidation, with PE-backed market share exceeding 30% or even 50% in many geographic markets.[23,35] Beyond PE, MSOs serve as vehicles for broader corporate consolidation, including payer-backed acquisitions (e.g., UnitedHealth/Optum), retailers (e.g., CVS, Walgreens), and drug wholesalers aggressively entering physician practice ownership.[36–38]

Impact on Prices and Utilization. Although MSOs justify physician practice consolidation with promises of increased operational efficiencies and enhanced care coordination, there is little evidence of such efficiencies or care improvements. Rather, the evidence suggests that the market consolidation of physician practice markets via corporate MSOs leads to higher health care prices and spending. While the literature does not directly measure the impact of MSOs on price and quality, we can infer their effects from research on corporate-backed physician practices, particularly those owned by PE firms. Corporate backing of physician practices, such as PE backing, has been shown to drive up health care costs, with research indicating that PE acquisitions raised prices by 11% in dermatology, gastroenterology, and ophthalmology,[39] while neonatology prices surged by 70%.[40] A study on gastroenterology practices found that PE acquisitions led to a 28.4% increase in claim prices, primarily driven by a 78.1% rise in professional fees.[41] Additionally, PE-backed practices have altered prescribing patterns, often favoring higher-cost medications, which has increased Medicare spending.[42] Moreover, this price increase does not always correlate with improved care quality. Consolidation has been linked to negative impacts on patient outcomes, such as higher rates of hospital-acquired infections and adverse events following PE acquisitions.[43] That said, research also shows that the impact on care quality is not universally negative. Some studies report outcome benefits in settings of fertility clinics, and some show improvements or no change based on the type of clinical setting and outcome being measured.[44,45] While much of the literature focuses on PE acquisitions, payer-backed MSOs likely follow a similar playbook, leveraging their market power to drive consolidation and influence physician decision-making.

B. CPOM Evasion and Physician Dissatisfaction

MSO Evasion of State CPOM Laws. The use of MSOs by PE firms and other corporate investors raises concerns about compliance with CPOM laws and the professional dissatisfaction of physicians. CPOM laws generally prohibit lay-owned corporations from owning medical practices or employing physicians[46] and require medical practices to be majority or exclusively owned by licensed

professionals. The MSO structure is designed to separate clinical and business operations: a professional corporation (PC) — owned by licensed physicians — retains ownership of the medical practices, while the MSO, owned by corporate entities, can support certain non-clinical functions such as administration, billing, and revenue collection.

The concern, however, is that the MSO, if it assumes too much control over the business and administrative functions of the practice, will impede the nature and quality of clinical care delivered. A powerful MSO may begin to invert the PC-MSO relationship, effectively subordinating the PC's physician owners to the MSO, rendering them functional employees of a corporate entity. This can easily present a clash of interests: If the MSO is singularly interested in pursuing profits, its motives may conflict with physicians' commitment to patient care.

The structure that presents the greatest risk of this inversion of control is the "friendly" physician model. Here, the MSO installs a physician to act as the PC's nominal owner. This arrangement enables the MSO to control the practice via the friendly physician owner, who is a licensed physician, albeit one who answers to the corporate MSO. The physician is often a direct employee of the MSO, such as its chief medical officer, who becomes licensed in states across the country and then can serve as the sole owner of all the entities' medical practices in the state. If not a direct employee, the friendly physician can be controlled by the MSO via contracting. In either case, the MSO can construct these arrangements to effectively act as shadow owners of the practice while remaining CPOM compliant on paper.

Though the friendly PC structure has existed for decades, its growing use by PE and other corporate entities is renewing scrutiny from state lawmakers and regulators, as we detail in the next section.[47] These arrangements have also spurred recent action in the courts. In *American Academy of Emergency Medicine Physician Group, Inc. v. Envision Healthcare Corporation,*[20] Envision Healthcare, a PE-backed MSO that operates as an emergency room staffing company, was accused of utilizing the friendly physician model in violation of California's CPOM ban. Plaintiffs alleged the staffing company took control of staffing decisions, scheduling, and the budget and billing of the PC, while limiting physician autonomy and mobility through restrictive covenants. While the court denied Envision's motion to dismiss, acknowledging that the allegations, if proven, could present a clear CPOM violation, Envision withdrew from California before the case could reach a final ruling, effectively avoiding a definitive legal judgment.[48]

The Effects on Physician and Practitioner Morale. Loss of physician autonomy and de facto ownership by corporate entities creates concerns about professional demoralization.[49] Physicians may experience moral injury if their professional autonomy and ethical commitment to patients is subordinated to the cost and revenue targets of financial investors and corporate owners.[50,51] Such concerns are reflected in recent reporting at medical practices functionally owned by Optum, the subsidiary of UnitedHealth Group that now employs or is affiliated with 10% of all American physicians. Physicians reported increased administrative burdens, reduced flexibility in tailoring care due to standardized protocols, and increased pressure to maximize patient volumes, often at the expense of care quality.[36] Other reporting found that Optum pressured physicians to take on high patient volumes and code patients as having conditions that providers felt were incorrect.[52] Some doctors observing these practices quit after their groups affiliated with UnitedHealth Group. PE-backed MSOs create similar concerns, particularly given the demand for short-term returns. Similar concerns arise in the PE context, where the demand for short-term profits can lead to financial and administrative decisions largely directed by the MSO. For instance, post-acquisition workforce changes and other cost-cutting measures — such as reductions in staffing or the hiring of lower-cost providers — may affect patient care and clinician retention.[53–55]

POLICY OPTIONS TO REGULATE MSOS

Currently, state oversight over material health care transactions involving corporate MSOs and physician practices is limited. First, there is little data collection at the federal or state levels on physician practice management or ownership. Second, MSO transactions involving physician practices either are too small to be reported to antitrust authorities or take the form of contractual affiliations that evade scrutiny by health care market

oversight programs (which mostly focus on mergers and acquisitions involving nonprofit hospitals and mergers). Third, MSOs can contractually circumvent most existing CPOM laws and exercise control over the PCs they are affiliated with. To address these gaps, states can pursue three policies to increase oversight over corporate MSOs and their control over medical practices through (1) requiring transparency of ownership and control; (2) expanding material health care transaction review; and (3) strengthening protections against CPOM and restricting physician non-compete agreements and other restrictive covenants.

1. Require Ownership Transparency

Currently, there is limited information about the ownership structures of health care practices, which may obscure the financial backers of a health care entity and the associated potential conflicts of interest in an organization's leadership. Moreover, without oversight, MSOs may be able to make decisions that diminish patient care quality by acting through a "friendly" physician, as described above.

State-level legislation could address this issue by requiring health care entities to:

- report any MSOs partnered with the practice,
- disclose any controlling financial interests (such as PE firms), and
- identify the leadership individual of both the practice and the MSO.

In January 2025, a Massachusetts law, An Act Enhancing the Market Review Process,[56] established the nation's strongest ownership transparency regulations for health care entities, particularly targeting PE firms, MSOs, and real estate investment trusts. The law requires corporate investors to disclose financial transactions with provider entities and mandates annual — and in some cases quarterly — reporting of disclosures covering ownership structures, financial stability, and contractual affiliations to the state's Center for Health Information and Analysis. The law also expands the Health Policy Commission's oversight by requiring MSOs and other corporate investors to publicly testify at annual cost trend hearings, thereby improving regulatory oversight and transparency over the financial and operational influence of corporate entities. In 2025, legislation was introduced in Washington State that would enact a transparency regime similar to the one in Massachusetts.[57]

2. Expand Material Transaction Review

States can enhance antitrust scrutiny by increasing their oversight authority over transactions in statute. Policy options to enable scrutiny of health care transactions both proactively and reactively include:

- Requiring parties to submit prior notice of material transactions involving health care entities.
- Establishing the authority to block or conditionally retract the transaction without a court order.
- Establishing the authority and process to continually monitor the transaction after it is complete.

Currently, 10 states require prior notice of transactions involving provider organizations, with Oregon further requiring prior approval.[58] New York's law requiring reports of material health care transactions, which took effect in August 2023,[59] explicitly extends review to MSOs of health care facilities. Similarly, as mentioned earlier, Massachusetts's market reform law requires prior notice of material health care transactions involving MSOs. In the 2024 legislative session, California's AB 3129 would have required prior approval of transactions involving PE and hedge funds — common MSO stakeholders — but the bill was vetoed by the governor.[48]

3. Strengthen State Bans on CPOM Laws

To safeguard a given provider when their practice contracts with an MSO, states can enact policies to strengthen their CPOM laws to target the mechanisms used by MSOs to influence care by:

- Barring individuals from having financial interests or significant control over both a practice and an associated MSO.
- Banning restrictive contractual provisions, such as non-disclosure agreements, non-disparagement clauses, and stock transfer restriction agreements.
- Requiring owners of a PC to be active providers who are directly involved in delivering care within the state where the PC operates.

Recent legislative efforts across several U.S. states aim to curb the influence of MSOs and reinforce CPOM protections. Oregon's SB 951, which nearly passed both chambers in 2024 and has been introduced for the second consecutive year in the 2025 legislative session, seeks to ensure that medical practices retain de facto control over clinical and administrative operations.[60,61] It prevents MSOs from installing "friendly" physicians or otherwise subordinating the physician owners of the medical practice to the managerial control of the MSO. Similar legislation was introduced in 2024 in Massachusetts[56] and in 2025 in Washington.[57] California's AB 3129, referenced above, also proposed to codify existing medical board guidance on the role of MSOs.[62] Those provisions, though less robust than the bills in other states, have been reintroduced in the 2025 session.[63]

While these legislative measures reflect a growing trend to address the complexities of CPOM laws, they also come with limitations. For instance, certain health care sectors, like telehealth, heavily rely on the friendly PC structure and could struggle to adapt to updated CPOM laws. Moreover, some physician-owned practices may be financially distressed and experience a binary choice of selling their practice to corporate-backed MSO or being acquired by a hospital system. Thus, CPOM laws looking to sustain independent practice may need to couple these laws with policy proposals that reduce administrative burdens on independent clinicians and provide alternative forms of capital support or reimbursement for independent practice.[47]

CONCLUSION

MSOs have evolved into a powerful force shaping the modern health care landscape, mirroring the growing corporatization of physician practices. While MSOs offer physicians critical administrative support, operational efficiencies, and financial backing, their growing role in corporate consolidation raises important concerns about market power, health care costs, and physician autonomy. As MSOs continue to expand under PE and corporate ownership, striking a balance between their benefits and risks becomes essential. Thoughtful policy interventions — ranging from ownership transparency measures to stronger CPOM protections — can help ensure that MSOs serve as enablers of quality care rather than drivers of unchecked corporate influence.

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