The End of Business as Usual?

Washington's 2026 CPOM Legislation

Washington State Society of Healthcare Attorneys (WSSHA)
University of Washington School of Law
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Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Peter D. Ricoy
Healthcare Attorney
Beeghly Ricoy Law Group
peter@beeghlyricoy.com

Melanie Maurice
Healthcare Attorney
Beeghly Ricoy Law Group
Melanie@beeghlyricoy.com

What is the Corporate Practice of Medicine, Anyway?

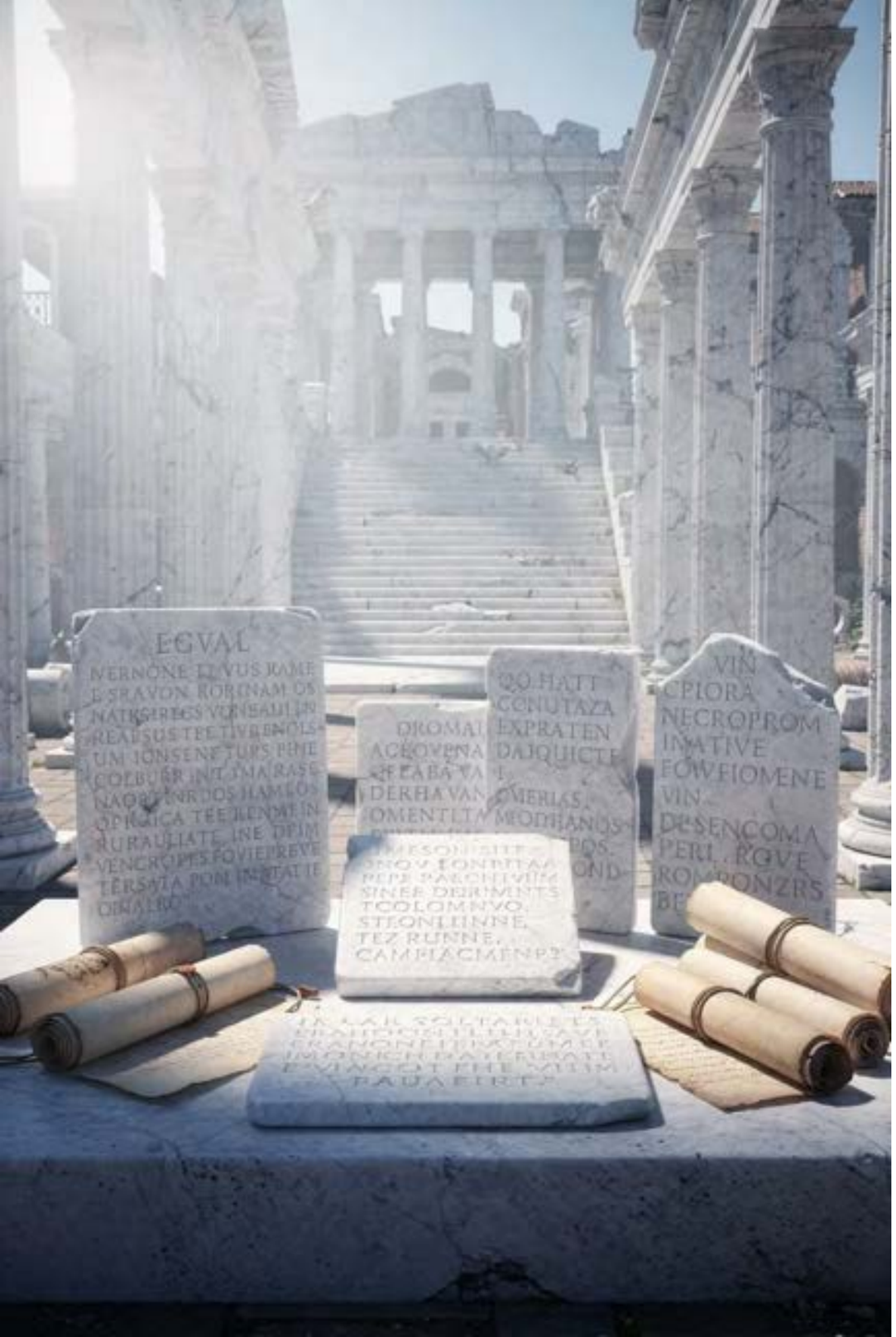
In U.S. law, a corporation is a legal person — it can own property, enter contracts, sue, and be sued.

We allow corporations to build things, sell things, and employ people. We limit liability of corporate owners.

We also regulate doctors — they must be trained, licensed, and personally accountable.

The question becomes: Should a corporation be allowed to "practice" medicine?

Or does healing the human body require a human conscience?



Where did Corporations Come From?

Roman Law — *Collegia* and *Universitates*

- Early legal "bodies" for religious, civic, and burial associations
- Created continuity across generations

Medieval Europe — The Moral Corporation

- Church and monasteries: enduring property-holding bodies
- The Crown, guilds, and universities: "corporations aggregate"
- Not for capitalism — for order, governance, and permanence

Where did Corporations Come From? (continued)

Early Modern Era — The Joint-Stock Company

- 17th–19th centuries: East India Co., VOC, trading empires
- Purpose: commerce, capital, and risk-sharing

American Adaptation — Incorporation as a Right

- From royal privilege to legal process
- *Dartmouth College v. Woodward*, 17 U.S. (4 Wheat.) 518 (1819): corporate charter as a protected contract

The Corporation as a Legal 'Person'

14th Amendment

- "No state shall deny any person equal protection of the laws."

Santa Clara County v. Southern Pacific R.R., 118 U.S. 394 (1886)

- "The Fourteenth Amendment applies to corporations."

Citizens United v. FEC (2010)

- Corporate political speech = First Amendment right.

From Industrial Medicine to Legal Doctrine

Industrial Pressure

- Company doctors on salary
- Corporate-owned medical institutes

Professional Concern

- Answer to shareholders, not patients
- Threat to physician loyalty

Organized Response

- AMA rejects the practice
- Courts turn ethics into law

The Foundational Cases

State Courts Build the Doctrine (1930s)

Early Cases

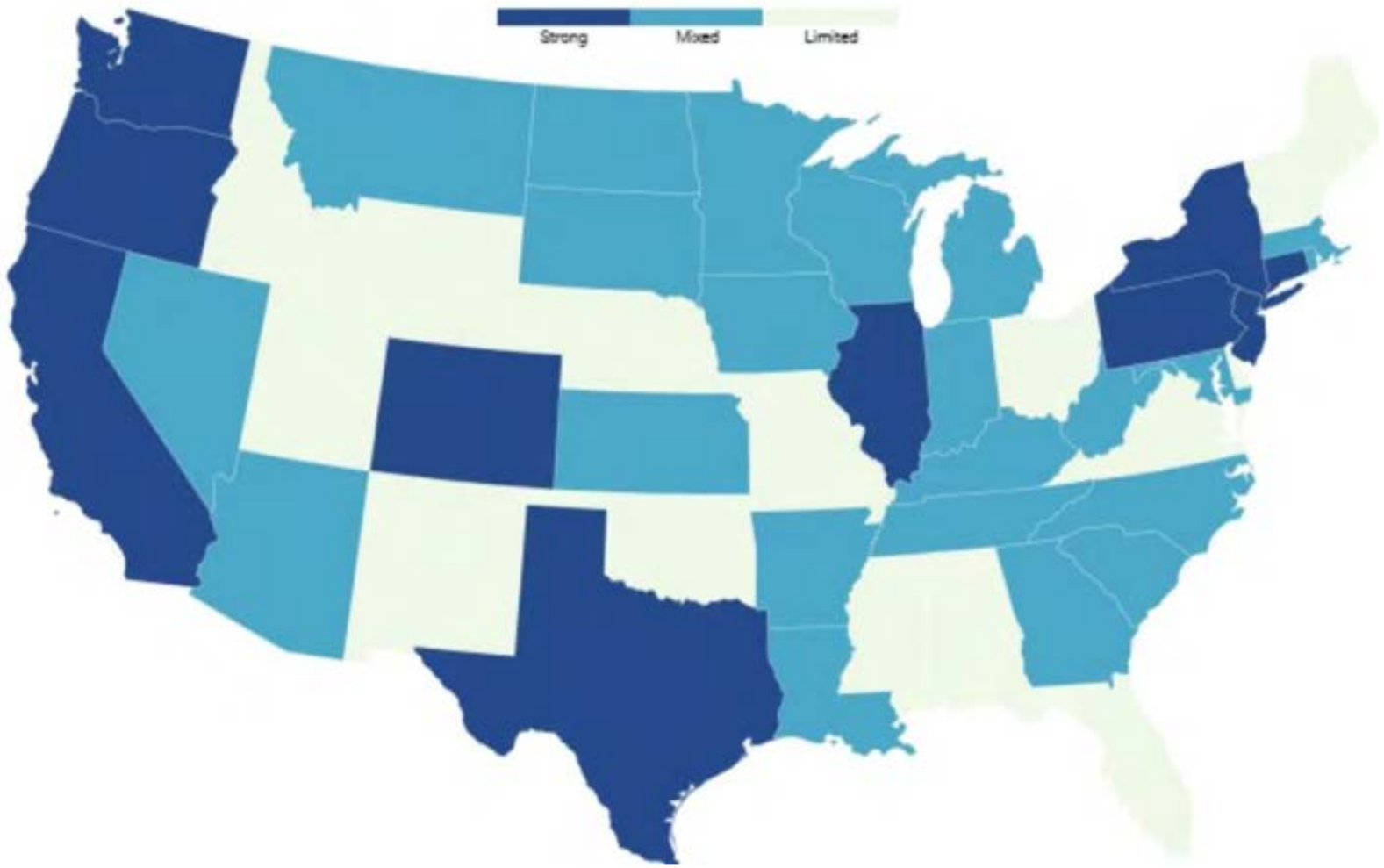
- **Painless Parker** (Cal. 1932) — no "business side" exception
- **Granger v. Adson** (Minn. 1933) — "no place for a middleman"

Doctrine Crystallizes

- **Semler** (U.S. 1935) — states may deny corporations the right to practice
- **United Medical Service** (Ill. 1936) — corporate clinics barred

Three rationales still anchor CPOM: lay control, commercialization, divided loyalty.

Today, Variation in State Corporate Practice of Medicine Doctrine



REGULATORY FRAMEWORK

Two Primary Regulatory Approaches to Corporate Influence in Healthcare

States are increasingly responding to concerns about corporate influence in medicine. These efforts generally fall into two primary approaches:

1. Structural Regulation (CPOM-Based)

Focused on ownership, governance, and control of clinical decision-making

2. Transactional / Market Oversight Regulation

Focused on healthcare transactions, consolidation, and market impact

These approaches reflect different regulatory strategies addressing the same core concern: preserving clinical independence while managing corporate influence.

REGULATORY FRAMEWORK

Structural Regulation (CPOM-Based)

Core Focus

- Who is allowed to control the practice of medicine
- Preservation of independent clinical judgment

Key Features

- Restrictions on MSO influence and "de facto control"
- Physician ownership and governance requirements
- Limits on corporate involvement in clinical decisions

Representative States

- Oregon (SB 951 – comprehensive reform)
- California (SB 351 and enforcement posture)
- Washington (proposed legislation)
- Vermont, Connecticut, North Carolina (emerging proposals)

Regulates the structure of healthcare organizations to ensure physicians retain control.

REGULATORY FRAMEWORK

Transactional / Market Oversight Regulation

Core Focus

- Oversight of healthcare transactions and consolidation
- Monitoring market power, cost, and access

Key Features

- Pre-closing notice or approval requirements
- Attorney General or agency review
- Analysis of competitive and cost impacts

Representative States

- Massachusetts (Health Policy Commission model)
- Minnesota (transaction review laws)
- Oregon (Health Care Market Oversight program)
- Washington, New York, Illinois, Nevada, New Mexico

Regulates healthcare deals and market activity rather than internal governance structures.

OREGON CPOM

Oregon's 2025 CPOM Law: A Major West Coast Shift

Moves Oregon from common-law CPOM principles to a detailed statutory framework

Directly targets MSO and "friendly physician" model overreach

One of the most aggressive states in limiting non-clinician control over medical practice

OREGON CPOM

The Centerpiece: No "De Facto Control" by MSOs

Prohibited Influence

- Hiring, firing, or setting clinician pay
- Setting staffing levels or visit lengths
- Controlling coding, pricing, or payer contracting
- Setting clinical protocols or care policies

Practical Meaning

- Compliance turns on functional control
- Not just formal documents
- Many MSO provisions are now high-risk
- Operational influence can trigger CPOM exposure

OREGON CPOM

Governance Rules Now Matter More Than Ever

Director Removal Restricted

Non-licensees cannot remove physician directors.

Transfers Tightly Limited

Control transfers must fit narrow statutory parameters.

Clinician Shareholder Control

Key governance must remain with licensed clinician owners.

OREGON CPOM

Why Oregon's Law Is a Big Deal for Healthcare Transactions

Immediate Effects

- Physician noncompetes broadly void; NDAs restricted
- New cause of action with damages and attorney fees
- Key MSO restrictions effective January 1, 2026

Business Impact

- Existing MSO structures need immediate review
- Governance and management agreements may need redesign
- Raises compliance bar for investor-backed multistate platforms

Oregon's First Big Test

Stapleton v. PeaceHealth (D. Or. 2026)

The Setup

- PeaceHealth ends 35-year ED contract
- ApolloMD forms Lane Emergency Physicians

The Dispute

- Plaintiffs say LEP is a sham front
- Defendants say MSO provides admin support

First federal test of Oregon's friendly-physician ban under SB 951.

SECTION OVERVIEW

California SB 351 — Overview and Legislative Context

California Health & Safety Code §§ 1190 et seq. (SB 351, Ch. 409, Stats. 2025; effective Jan. 1, 2026)

A Strict CPOM State Gets Stricter

- Codifies existing CPOM limits
- Explicit rules
- Direct enforcement

Targeted Scope: PE and Hedge Funds

- Private equity
- Hedge funds
- MSOs only; hospitals excluded

Companion Legislation: AB 1415

- More transaction reporting
- More state oversight
- PE-backed deals

Legislative Intent

- Clinical judgment stays with licensed providers
- Business terms cannot displace physician judgment

Key Legal Provisions — What SB 351 Prohibits

Cal. Health & Safety Code §§ 1190–1190.8

Prohibition on Interference with Clinical Judgment

- Diagnosis and treatment
- Referrals and consultations
- Workload and patient volume

Restrictions on Control Over Clinical Operations

- Coding and billing
- Clinical staffing decisions
- Payer contracts and records

Contractual Consequences Under SB 351

Void & Unenforceable Agreements

Any agreement enabling prohibited clinical control is void as against public policy.

Noncompete Clauses

Physician noncompetes are void; only narrow sale-of-business exceptions survive.

Nondisparagement Provisions

Provisions restricting discussion of care quality, ethics, or revenue strategies are void.

Confidentiality Carve-Out

Confidentiality provisions protecting material nonpublic information remain permissible if not used to suppress protected disclosures.

Enforcement Framework

From Licensing Boards to the Attorney General

SB 351 shifts enforcement from the Medical Board's reactive licensing process to direct AG action. The California Attorney General may seek injunctive and equitable relief against covered entities — PE firms and hedge funds — as institutional actors.

Prior Model

Medical Board licensing & discipline: reactive, provider-focused, limited reach

SB 351 Model

AG injunctive & equitable relief: proactive, entity-focused, broad scope

Operational Impact — What Counts as "Administrative" Has Changed

Functions Now Expressly Regulated

- Coding, billing, staffing, and equipment decisions are now regulated
- MSO contracts vesting control in non-physicians are legally defective

"Friendly PC" Models Are Not Insulated

- Nominal physician ownership does not provide safe harbor under SB 351
- Functional control by covered entities makes ownership structure legally irrelevant

Risk Assessment

Enforcement Exposure and Litigation Risk

AG Enforcement Action

The Attorney General's new authority to seek injunctive and equitable relief introduces **meaningful regulatory exposure** at the entity level. PE groups and hedge funds can no longer rely on the diffuse, provider-centered enforcement model that characterized prior CPOM oversight.

Provider-Driven Disputes

Physicians and dentists now have a **statutory basis** to challenge MSO control provisions as void and unenforceable. Contract disputes, rescission claims, and breach allegations are all viable theories that providers may deploy against PE-backed entities under the new framework.

Whistleblower Activity

The voiding of nondisparagement clauses significantly **increases whistleblower risk**. Clinical staff who were previously contractually constrained from discussing care quality, utilization, or revenue strategies may now speak freely — and may be actively encouraged to do so by plaintiffs' attorneys and regulators.

NATIONAL TRENDS

States Considering "West Coast–Style" CPOM Reform

Vermont

- Most aggressive current proposals
- Targets MSO and investor control

Connecticut

- Active proposals on management arrangements
- More incremental, but aligned

North Carolina

- Growing interest in practice control
- Signals broader reform expansion

Key Takeaways for Healthcare Counsel

Audit Now, Before Jan. 1, 2026

Review MSO agreements and employment documents for provisions void under SB 351.

Restructure for Functional Compliance

Governance and workflows must keep clinical control with licensed providers in fact.

Monitor Multistate Developments

California and Oregon lead; Washington and others are close behind.

Elevate Enforcement Risk Counseling

AG enforcement, provider disputes, and whistleblower exposure are now live risks.

The Regulatory Landscape in Washington

Professional Service Corporation Act (PSCA)

Chapter 18.100 RCW governs professional service corporations. Owners must be **duly licensed** in the specific profession, and the entity may not engage in other business activities.

Professional Limited Liability Companies (PLLC)

RCW 25.15.046 requires all directors and officers — except the secretary and treasurer — to hold active professional licenses in the relevant discipline.

Statutory Exceptions & Limitations

Hospitals

Chapter 70.41 RCW implies an exception, but **no reported case law** defines its scope.

Independent Contractors

The CPOM doctrine does **not** bar unlicensed entities from hiring licensed professionals as independent contractors.

Dental Firms (RCW 18.32.677)

DSOs may charge percentage-based fees for leasing and administration, **so long as they do not interfere with clinical judgment**.

LANDMARK CASE

Columbia Physical Therapy

Columbia Physical Therapy v. Benton Franklin Orthopedic Associates (2010)

Holding

Physical therapy is an **"aspect of the practice of medicine."**

Implication

A physician-owned medical PLLC may employ physical therapists.

Risks of Non-Compliance

Government Enforcement

Regulatory action can lead to **dissolution of the corporate charter** or major state civil fines.

Contractual Avoidance

Courts may **refuse to enforce** leases, management agreements, or other CPOM-violating contracts.

Illegal Partnership Precedent

In *Fallahzadeh v. Ghorbanian* (2004), a lease was voided as an **"illegal partnership"** when rent tied to 50% of net profits exceeded fair market value.

Government Enforcement Actions

Enforcement Mechanisms

The **Unlicensed Practice Program** investigates cases where unlicensed persons exercise clinical control. Licensed professionals may also face discipline under **aiding and abetting** standards for enabling unlicensed practice.

Comfort Dental (2016)

$340,000 civil fine for a franchise model that restricted clinical vendors and mandated provider hours.

Half Dental (2014)

Agreed order to **cease operations** after management contracts granted control over all business records, billing and collection duties, the ability to hire support personnel, control over bank accounts, control over litigation in the dentist's name, a 100-mile noncompete, and compensation based on revenue and profits.

Transactional Strategy: The PC Model

1

Management Company

Owned by unlicensed investors. Provides admin support, equipment, billing, and non-clinical staff.

2

Contract & Fair Market Fees

Fees must reflect **fair market value** — not a hidden ownership return — to pass regulatory scrutiny.

3

Professional Practice

Owned by licensed individuals. Keeps clinical control, payer contracts, and provider relationships.

"Captive" or "Friendly" PC Models & Clinical Control

The Captive PC Structure

Unlicensed investors identify a supportive licensed professional as the nominal practice owner. **Stock transfer restriction agreements** or succession agreements may control ownership transfer — a **high-risk** approach in Washington, where courts look past formalities to assess actual control.

Indicators of Violation

- Setting frequency or duration of patient care
- Controlling medical records or denying provider access
- Directing hiring or termination of clinical staff

The more a management company controls clinical outcomes, the greater the risk of an unlicensed practice citation.

Conclusion & Best Practices

Washington courts prioritize **substance over form** in CPOM disputes. Structural compliance alone is not enough; the reality of control will govern.

Independent Valuations

Management agreements should be backed by independent fair market value reviews.

Reserve Clinical Judgment

Preserve all clinical and professional decision-making authority for the licensed provider.

Aiding & Abetting Risk

Counsel advising medical directors should watch for discipline exposure tied to unlicensed practice.

Washington State Legislative Context

National Academy for State Health Policy (NASHP) driving reform

- NASHP develops and advances state health policy innovations and solutions.

NASHP comprehensive consolidation model legislation

Intent:
Address issues of consolidation, closures, and corporate and private equity involvement in the health care market.

Goal:
Increase affordability and access to care by increasing state oversight.

Model provisions include:

- Expanding market & transaction oversight
- Strengthening CPOM laws
- Requiring transparency of health care ownership and control structures

WA state officials are engaged

- NASHP framework generally aligns with Washington's CPOM legislation to address corporate and private equity involvement in the health care market.

3SSB 5387: Codifies and expands WA's CPOM doctrine

Allows only medical licensees to own a medical practice, employ licensed health care providers, or otherwise engage in the practice of medicine.*

Medical licensees: MDs, DOs, ARNPs, PAs, and naturopaths

In a PC, medical licensees must:

- Hold all voting shares, director positions, and officer positions*
- Exhibit meaningful ownership

Prohibits medical licensees from:**

- Owning or controlling shares or equity in the MSO.
- Being an employee or independent contractor of the MSO.
- Participating in the management of both the medical practice and the MSO.
- Receiving substantial compensation or renumeration from the MSO.
- Transferring or relinquishing control over the sale or the issuance of shares of stocks.*
- Relinquishing or transferring over admin, business, or clinical operations via contract or other means.

Prohibits individuals other than medical licensees from:
Interfering, controlling, or directing the professional judgment or ultimate clinical decisions of a licensed health care provider.

Prohibited conduct includes controlling:**

- Time spent with patients
- Clinical admit and discharge planning
- Diagnoses, diagnostic terms, or codes
- Range of clinical orders available for services at the facility or available through referral

*Exceptions apply **Non-exhaustive list

3SSB 5387: Issues

Creates Operational & Compliance Challenges

- ❑ Blurs operational and clinical decision-making
- ❑ Weakens support systems and increases administrative burden
- ❑ Contains insufficient exemption language

Requires continued refinement to address:

- ❑ Statutory conflicts
- ❑ Ambiguities
- ❑ Broadness

CPOM: Legislative Outlook

Significant Legislative Interest

Future Legislation

- 2025 bill will not return
- Likely to see same or similar CPOM legislation in 2027 or future sessions

WSHA Advocacy

- Ensure bill language meets stated intent
- Address unintended consequences
- Create a workable process

Questions & Discussion

We welcome your questions and comments

Thank you!

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Peter D. Ricoy
Healthcare Attorney
Beeghly Ricoy Law Group
peter@beeghlyricoy.com

Melanie Maurice
Healthcare Attorney
Beeghly Ricoy Law Group
Melanie@beeghlyricoy.com