Simpson Thacher

Memorandum

"Stop Corporate Takeovers of Physicians Act of 2026" Bill Would Establish a Federal Corporate Practice of Medicine Ban and Restrict Management Services Organization Arrangements

September 25, 2026

On September 16, 2026, Members of Congress[1] introduced the "Stop Corporate Takeovers of Physicians Act of 2026" (H.R. 10444) (the "Bill"), which, if enacted, would establish the first-ever federal corporate practice of medicine ("CPOM") ban and impose significant new restrictions on management services organization ("MSO")[2] structures. The Bill's broad language would apply to major healthcare, telehealth, and technology companies, since payer-owned physician platforms, retail health entrants, and the direct-to-consumer healthcare sector generally rely on the MSO and professional corporations ("PC") structure that the Bill would regulate. The Bill would establish federal restrictions on the ownership and control of healthcare providers by corporate entities (*e.g.*, LLCs, LLPs, partnerships, and PCs) that are not majority-owned and controlled by licensed physicians or other advanced practice healthcare providers substantially engaged in delivering medical care.

The Bill draws on provisions in Oregon's recently enacted CPOM legislation, known as Senate Bill 951 ("SB 951"), and may serve as a template for additional state-level legislative proposals. Though the Bill is unlikely to advance in the current Congress, its provisions would significantly change the ways in which healthcare providers may control or direct the practice of medicine by other providers. The Bill also contains new non-compete protections for physicians and other licensed health professionals. Hospitals, private equity ("PE") sponsors, and other industry participants with exposure to physician practice investments or MSO structures should evaluate the Bill's potential restrictions on healthcare providers; assess whether they have employed such concepts in medical practices (*e.g.*, configuring medical records in a manner that could influence clinical decision-making); and monitor potential future hearings and markups of the Bill.

[1] The Bill's sponsors include Senators Wyden, Merkley, and Warren, and Representatives Hoyle, Ocasio-Cortez, and Subramanyam.

[2] Under Section 2(d)(4)(A) of the Bill, MSO means an entity that has entered into an agreement with a medical practice to provide services to such practice in return for compensation, including HR, IT, payroll, payer contracting, billing and coding, collections, patient scheduling, property or equipment leasing, and administrative or business. Under Section 2(d)(4)(B), an entity shall be deemed to be providing services that constitute the practice of medicine if the provision of such services affects the patient-licensee relationship, including by performing an evaluation of a patient that results in the formulation of a differential diagnosis, diagnostic plan, therapeutic plan and disposition of the patient, and imposing an administrative or facility-based measurement or restriction on any portion of the patient-licensee relationship.

Key Takeaways

- **Federal CPOM ban**: The Bill would prohibit CPOM nationwide, making it unlawful for an entity that is not majority-owned and controlled by one or more licensees[3] to own or control a medical practice,[4] employ or contract for the professional services of a licensee, or engage in the practice of medicine. The Bill exempts non-profit and public healthcare providers[5] and hospitals (including hospital-affiliated clinics, critical access hospitals, and rural emergency hospitals) from the ownership ban, but hospitals would remain subject to the Bill's clinical autonomy protections and restrictive covenant prohibitions in employment agreements. Potentially affected companies should assess ownership, governance, and hospital-affiliation structures against both the exemption and its limits.
- **Sweeping MSO restrictions**: The Bill would prohibit MSOs from controlling medical-practice shares, ownership interests, or assets; issuing medical-practice equity; paying dividends from medical-practice interests; acquiring medical-practice interests; advertising under a non-practice name; and exercising de facto control over specified administrative, business, or clinical operations. Current MSO and medical practice arrangements often include share transfer agreement restrictions and several of these restricted services. Affected parties would need to restructure existing arrangements if the Bill were enacted.
- **Retroactive application to existing arrangements**: Unlike Oregon's SB 951, which imposed MSO restrictions on newly formed entities beginning January 1, 2026, while granting pre-existing arrangements a transition period until January 1, 2029, the federal Bill contains no comparable grandfathering provision and would apply to all existing MSO arrangements after a one-year phase-in. Any agreement between an MSO and a medical practice that violates the Bill's restrictions would be deemed void and unenforceable. As a result, existing MSOs would have a limited window to implement new management services agreements and engage in arm's-length negotiations.
- **Multiple enforcement mechanisms**: The Bill would authorize FTC enforcement, a private right of action, state attorney general actions, mandatory injunctive and equitable relief, and exclusion from federal healthcare programs—a significant consequence for healthcare providers.
- **State laws are not preempted**: The Bill would preserve more restrictive state laws and permit states to maintain or adopt stricter ownership, licensee-protection, and MSO requirements.
- **Legislative outlook**: Although H.R. 10444 is unlikely to pass in the current Congress, the Bill may serve as a model for state legislative efforts, with its longer-term prospects depending in part on the results of the November 2026 mid-term elections.

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[3] Under Section 2(d)(3) of the Bill, "licensee" means a physician (as defined in section 1861(r)(1) of the Social Security Act ("SSA")) or other advanced practice provider such as a physician assistant or nurse practitioner (as those terms are defined in section 1861(aa)(5) of the SSA) who is authorized under state law to diagnose and treat patients in a clinical setting.

[4] Under Section 2(d)(5) of the Bill, "medical practice" means a partnership or corporate entity, such as a PC, LLC or LLP, that is organized for the purpose of practicing medicine.

[5] Under Section 2(d)(2) of the Bill, a healthcare provider means any entity that delivers healthcare services and includes a medical practice.

Federal CPOM Ban

Outside of certain exemptions,[6] a partnership or corporate entity (including a LLC, LLP, and a PC) that is not majority-owned and controlled by one or more licensees could not: (1) own or control, in whole or in part, a medical practice; (2) employ, or contract for the professional services of, a licensee; or (3) engage in the practice of medicine. For purposes of the Bill, majority ownership and control requires both (a) majority ownership by licensees and (b) licensee control of a majority of the entity's governing body.

The Bill also imposes requirements that narrow the licensees that are eligible to own medical practices. Licensee owners of a medical practice would be required to be licensed and present in a state where services to patients are furnished by the practice and substantially engaged in delivering medical care. If implemented, this requirement would be inconsistent with current trends of multistate medical practice ownership and may require restructuring of ownership arrangements to ensure that owners are actively practicing in the relevant jurisdiction. For existing portfolio companies and pending transactions, ownership diligence should test these requirements on a state-by-state basis rather than assuming that a single physician can satisfy them nationwide.

Overview of MSO Restrictions

The Bill includes several controls on an MSO or any shareholder, director, member, manager, officer, employee, or contractor of an MSO related to arrangements with medical practices, and prohibits: share transfer agreements and other ownership and transfer controls; contracts between medical practices and MSOs that are not negotiated at arm's length and that do not have compensation that reflects fair market value (as determined by the FTC); advertising a medical practice's services under the name of an entity other than the medical practice; and control over administrative, business, or clinical operations in a manner affecting the nature or quality of care, including through ultimate decision-making authority over the specified functions discussed below.

MSO arrangements typically include several of the services and functions restricted under this Bill. If enacted, the legislation would require substantial restructuring of existing MSO arrangements to comply with these limitations. Importantly, these restrictions would apply retroactively to existing arrangements. Unlike the grandfather provisions in Oregon's SB 951, the federal Bill would apply to all existing MSO arrangements after a one-year phase-in. Any agreement between an MSO and a medical practice that allows the MSO to take any action in violation of these restrictions would be considered void, unenforceable, and against public policy.

Limitations on MSO Functions

The Bill would also bar an MSO from controlling or exercising de facto control over a medical practice's administrative, business, or clinical operations in a manner that affects the nature or quality of medical care. The non-exclusive statutory list addresses ultimate decision-making authority over:

[6] The Bill includes exceptions for non-profit and public healthcare providers and hospitals (including hospital-affiliated clinics, critical access hospitals, and rural emergency hospitals).

- **Workforce matters.** Hiring or terminating medical-practice employees; licensee work schedules, compensation, and other employment terms; staffing levels; and required degrees or credentials.
- **Clinical operations.** The time a licensee may spend with a patient, diagnostic coding, and clinical standards or policies.
- **Financial and billing matters.** Disbursement of revenue generated from licensee fees and services; revenue targets or other incentives; billing policies; and prices, rates, or amounts charged for licensee services.
- **Third-party arrangements.** Negotiation, execution, performance, enforcement, or termination of contracts with third-party payors or persons who are not medical-practice employees.

Current MSO arrangements with medical practices commonly allocate some of these functions to an MSO. If enacted, the Bill would require existing arrangements to be evaluated against both the listed functions and the broader prohibition on control affecting the nature or quality of care. For existing companies, this review should identify any operational controls that must move back to the physician practice. Pending deals should allocate diligence and remediation responsibility expressly, and potential acquirors should evaluate the merits of future pipeline opportunities with prohibited control rights as if such rights will not survive.

Non-Competes and Other Licensee Protections

The Bill includes several protections for licensees, though certain prohibited acts, such as controlling where a patient is referred upon discharge, would have previously raised concerns under federal and state anti-kickback statutes. Healthcare providers would be prohibited from directly or indirectly interfering with, controlling, or otherwise directing a licensee's professional judgment or clinical decisions through discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure. Specifically prohibited actions include specifying the period of time a licensee may spend with a patient, determining the clinical status of a patient, specifying how quickly a treatment should be initiated, exercising final decision-making authority over diagnoses or diagnostic terminology, and controlling or limiting the range of clinical orders available to licensees.

The Bill would also restrict certain covenants in employment agreements. The Bill would prohibit a licensee, healthcare provider, or MSO from entering into a non-compete clause or a non-disclosure or non-disparagement agreement. For a non-compete between a licensee and a medical practice to be permissible, the licensee must be a shareholder or member, or otherwise own or control an interest equivalent to at least 25% of the practice's total ownership or membership interests. Because non-competes are a core component of physician retention in many platforms, voiding them would create retention risk that would directly affect platform value and that should be considered in economic models.

Effective Date and Transition Period

The Bill would take effect one year after enactment. This timeline is significant, as the Bill would render any MSO agreement with a medical practice that violates its provisions void and unenforceable, and it applies retroactively

to existing arrangements. Current MSOs would have a limited window to renegotiate and restructure management services agreements and to satisfy the Bill's arm's-length negotiation and fair-market-value requirements. Existing companies may consider using the phase-in period for a documented remediation plan, while pending deals would need to consider allocating costs associated with compliance, closing timelines, covenants, and purchase-price assumptions if the Bill were to be enacted.

State Law Preemption

The Bill would establish a federal floor and preserve more restrictive state regimes. The Bill expressly provides that it will not preempt, displace, or supersede any equivalent or more stringent state law with respect to (1) ownership and control requirements on medical practices, (2) protections for licensees, or (3) restrictions on MSOs. As a result, healthcare and technology companies, investors, MSOs, and others would continue to navigate a patchwork of varying state-level requirements even if the Bill is enacted. Multistate companies and pending deals therefore should map state-by-state obligations before assuming that federal compliance would resolve their exposure.

Enforcement

The Bill establishes multiple enforcement mechanisms. The FTC would serve as the primary federal enforcement authority and would promulgate implementing regulations. The FTC would enforce the Bill with the same jurisdiction, powers, and duties as under the FTC Act, such as injunctive relief, including with respect to non-profit organizations that would otherwise fall outside the FTC's traditional jurisdictional scope. Violators would also be subject to the same penalties as under the FTC Act.

Beyond FTC enforcement, the Bill creates a private right of action for any person injured by a violation. Prevailing plaintiffs may be awarded treble damages, reasonable attorneys' fees and litigation costs, and other equitable or declaratory relief. State attorneys general would be authorized to bring civil actions on behalf of their residents, which could result in monetary damages and equitable relief. Courts finding a violation would have the power to order divestitures and to disgorge any revenue received from an entity subject to divestment during the period of violation.

Notably, the Bill permits exclusion from federal healthcare programs, including Medicare and Medicaid, for any entities that violate the CPOM, non-compete, licensee ownership or MSO restrictions. This potential for exclusion adds a significant additional enforcement dimension beyond civil remedies, as exclusion from federal healthcare programs can have severe financial consequences for healthcare providers and affiliated entities.

Legislative Outlook

While H.R. 10444 is not expected to be enacted during this Congress, state-level legislation is expected to advance, and bills such as Oregon's SB 951 and California's SB 351 and AB 1415 are already effective. State legislatures in Pennsylvania, Rhode Island, New York, Indiana, and Connecticut are expected to consider similar bills in 2027.

Healthcare companies and MSOs should therefore treat H.R. 10444 as a forward-looking state-law signal, not merely as a federal legislative proposal.

Recommended Next Steps

PE sponsors, healthcare and technology companies, and other affected stakeholders with MSO structures should consider the following steps: (1) Audit MSO agreements across all states for indicia of de facto control; (2) confirm that physician owners are licensed, physically present, and actively practicing in each state; (3) assess all non-compete, non-disclosure, and non-disparagement provisions for enforceability; (4) model restructuring costs for MSO arrangements that may need to transition to fixed fair-market-value fee structures; and (5) monitor 2027 state legislative sessions. For assistance evaluating the Bill's potential implications for physician-practice ownership, MSO structures, or healthcare transactions, please contact any of the Simpson Thacher attorneys below.

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