STRATUM HEALTH ADVISORS

CASE STUDY N° 17 · DECISION ANALYSIS

The Structure Underneath Everything

Why the corporate-practice-of-medicine doctrine — and how strictly each state enforces it — quietly determines how every physician-practice deal is built. The MSO structure and its state-by-state legal geography. A deal-structure analysis.

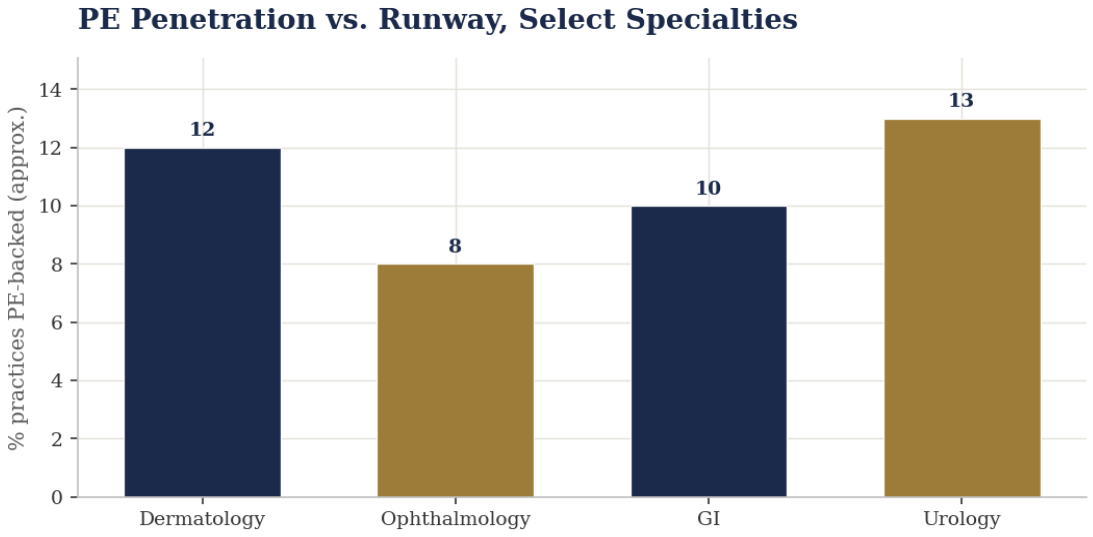
1. The Fork

Every private-equity investment in a physician practice runs into the same wall: in most states, non-physicians cannot own a medical practice. The workaround — the management-services organization, or MSO — is the structure underneath nearly every deal in this entire series. But how that structure must be built, and how much control the investor can actually hold, varies sharply by state. For an operator or investor, the decision is not whether to use an MSO but how to structure it in a given state's legal environment — and getting it wrong can void the transaction. This analysis explains the plumbing.

2. The Landscape Before the Decision

The corporate-practice-of-medicine (CPOM) doctrine holds that only licensed professionals may own and control entities that deliver clinical care. In states with strict CPOM enforcement, non-physician investors including PE firms cannot directly own a practice; transactions must instead be structured so a physician-owned professional corporation retains clinical control while a separate MSO provides administrative services under a management agreement[1].

This is why the entire consolidation wave — dermatology, ophthalmology, urology, dental, and the rest — is built on MSOs rather than direct ownership. The MSO handles billing, HR, IT, marketing, and real estate; the professional entity keeps clinical decisions, hiring of medical staff, and fee-setting[1]. The economic value transfers to the investor through the management agreement, not through direct ownership of the practice.



Illustrative | Source: FOCUS; KFF; Becker's (2024-26).

The runway for this structure is large because penetration remains modest across specialties — roughly 8–13% PE-backed depending on the field — leaving most of the market still to consolidate, all of it through MSO structures shaped by state law[2].

3. The Decision Logic — Steelmanned

The MSO structure exists because it genuinely reconciles two legitimate interests: it lets outside capital fund practices that need it, while preserving the legal principle that clinical decisions rest with licensed physicians. A well-built MSO gives the investor durable economics and the physicians real clinical autonomy — not a fiction, but a genuine division of authority. Investors accept the structure because it works: dozens of specialties have consolidated through it, and physician shareholders have realized substantial returns. The structure is not a loophole to be minimized; it is the operating reality of the entire physician-services investment thesis, and building it well is a core competence rather than a compliance afterthought.

4. The Landscape After

But the structure's validity depends on substance, not just form, and this is where state geography becomes decisive: regulators and courts look beyond the paperwork. An MSO arrangement that effectively gives a non-licensed entity control over clinical decisions, medical-staff hiring, or fee-setting can be deemed impermissible — risking fines, license discipline, or even voiding of the transaction[1].

The practical consequence is that the same deal must be structured differently in different states, and the strictness of a state's CPOM enforcement changes what an investor can actually control and therefore what a practice is worth to them. A strict-CPOM state constrains the management agreement more tightly; a permissive state allows the investor more latitude. This means a multi-state platform is not executing one structure but a patchwork, and a practice's location determines both how its deal must be built and how much operational control the acquirer can exercise post-close. An operator or investor who treats CPOM as uniform national boilerplate rather than a state-by-state variable is building on sand — the structure that is bulletproof in one state may be voidable in the next. Regulatory attention is also rising: recent federal scrutiny of anesthesia bundling in specialty MSOs signals that the structures themselves, not just their state-law form, are under a brighter light.

5. The Strategic Read — For Any Physician-Services Investor or Operator

The MSO is the mechanism under every physician-practice deal, and state CPOM law is the variable that shapes it. The tradeoff space:

STATE CPOM POSTURE	STRUCTURING IMPLICATION	RISK
Strict enforcement	Tightly constrained management agreement; physician entity holds more	Substance-over-form challenge if MSO overreaches
Permissive	More investor operational latitude	Fewer constraints, but rising federal scrutiny
Multi-state platform	A patchwork, not one structure	Uniform boilerplate voidable in strict states
The failure mode	Treating CPOM as national boilerplate	A structure bulletproof in one state, voidable in the next

6. The Stratum Outlook

IN PLAIN TERMS

Strip away the mechanics and it is this: in most states, an investor legally cannot own a doctor's practice — so every deal is built as a workaround where the doctors keep a company that owns the medicine, and the investor owns a company that runs everything else and collects the fees. That workaround is the foundation under every roll-up in healthcare. But it only holds if the doctors genuinely keep control of clinical decisions, and how strictly each state enforces that varies a lot. The same deal that is airtight in one state can be thrown out in the next. If you are investing in or selling a practice, the boring legal structure is not boilerplate — it is the thing that decides whether the deal survives, how much control the buyer really gets, and therefore what the practice is actually worth.

7. Where Stratum Fits

An investor or operator building or selling into a physician-services platform needs the MSO structure pressure-tested against each state's CPOM posture — what control is actually permissible, how it affects valuation, and where the substance-over-form risk lives. Stratum builds that structural read alongside licensed counsel. Start a conversation at stratumhealthadvisors.com.

References

All figures in this analysis are drawn from the following public sources, current as of publication (July 2026).

[1] Lindabury, McCormick, Estabrook & Cooper, “Navigating the Purchase or Sale of an Eye Care Practice,” July 2026. lindabury.com. (CPOM doctrine; MSO structure; substance-over-form; voiding risk.)

[2] GAO-25-107450, “Health Care Consolidation,” Sept 2025; FOCUS / KFF / Becker's specialty penetration data, 2024–2026. (MSO as the consolidation vehicle; PE penetration 8–13% by specialty; FTC anesthesia-bundling scrutiny.)

Figures reflect the most recent public sources available and may change as ownership and market conditions evolve. This reference list is provided for transparency and does not constitute an endorsement by the cited parties.