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Healthcare Alert

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Carbon Health settlement clarifies the California CPOM line for PC-MSO structures

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Carbon Health settlement reveals which contract terms California's AG treats as unlawful lay control and gives MSO operators a practical restructuring roadmap.

What's the impact?

- The settlement is the third in a sequence of California AG corporate-practice enforcement actions in 2026.
- The proposed judgment enjoins three structural features: management agreements granting the MSO complete operational authority, MSO ownership or option interests in a PC for its own benefit, and exclusive above-market captive financing.
- PC-MSO operators and their investors in California should review continuity and succession provisions, management-fee and financing terms, and governance arrangements against the features the AG has now identified across three enforcement signals.

On June 26, 2026, California Attorney General Rob Bonta announced a settlement with Carbon Health Technologies, Inc., its affiliated professional corporations, and its co-founder and former

CEO, Eren Bali (collectively, Carbon Health). The settlement addresses allegations that the company violated California's prohibition on the corporate practice of medicine (CPOM), used unlawful consumer contracts, billed patients and insurers improperly, and engaged in false advertising.

The settlement is not a ruling on the merits, but it provides a detailed view of the contractual terms the AG regards as problematic and the remedies the AG is prepared to pursue, which makes it instructive for any organization that operates a PC-MSO model in California.

The structure at issue and the AG's theory

Under California's CPOM prohibition, unlicensed persons and entities are barred from owning or controlling a medical practice. In the PC-MSO model, a licensed physician owns the professional corporation (PC), and a separately owned MSO contracts with the PC under a long-term management services agreement (MSA) for administrative and operational support. An MSO manages the non-clinical, business aspects of a practice, provided the PC and its physicians retain authority over the practice of medicine and the MSO does not interfere with clinical functions.

According to the AG's complaint, Carbon Health's MSAs granted the MSO authority over advertising, payor negotiations, selection of medical equipment, and the hiring, firing, and compensation of the licensed clinicians who worked for the PCs. The physician-owners also granted the MSO an assignable option permitting the MSO, in its discretion, to cause the PC's stock to be transferred to a physician selected by the MSO upon specified triggers, and the MSO held a security interest in the PC shares. Revolving credit arrangements required the PCs to borrow exclusively from the MSO at above-market rates. The AG alleged that, taken together, these provisions rendered the practices captive, subordinating the PCs' independent existence to the MSO's discretion.

What the proposed judgment requires

The proposed judgment imposes a $4,400,000 civil penalty against the Carbon Health entities and a $100,000 civil penalty against Mr. Bali personally.

The judgment permanently enjoins Carbon Health from engaging in the corporate practice of medicine, including prohibiting the following arrangements under Cal. Bus. & Prof. Code §§ 2052(a), 146(a); AG authority under Cal. Bus. & Prof. Code §§ 17203, 17535:

- An MSA that grants the MSO complete authority over advertising, payor negotiations, selection of medical equipment, and the hiring, firing, and compensation of licensed medical professionals;
- Granting the MSO any ownership interest in a PC, including through an assignable option

agreement that grants the MSO the right to acquire such ownership interests for its own account; and

- A revolving credit agreement requiring the PCs to obtain financing exclusively from the MSO at an above-market rate.

Complying with the injunction requires Carbon Health to restructure these arrangements so that the MSO no longer controls or holds an ownership interest in the PCs.

The financing prohibition carries an express carve-out: the MSO may take a first-priority lien in certain PC assets subject to conventional lender restrictions, distinguishing ordinary secured lending on market terms from financing used as a mechanism of control.

In addition, the judgment separately enjoins the consumer-facing conduct alleged in the complaint, including automatic credit- and debit-card charging without clear disclosure, billing HMO patients beyond permitted cost-sharing, debit-card billing without required notice, and advertising that misrepresented in-network status under Cal. Civ. Code § 1770(a)(19); Cal. Health & Safety Code § 1379(c); Regulation E, 12 C.F.R. §§ 205.10, 1005.10; Cal. Bus. & Prof. Code § 17500. These claims are outside the CPOM analysis but signal that the AG paired its corporate-practice theory with consumer-protection and billing enforcement in a single action.

The third beat in a coordinated enforcement sequence

Carbon Health follows two earlier developments that we analyzed in prior alerts. On March 30, 2026, the AG filed an amicus brief in *Art Center Holdings, Inc. v. WCE CA Art, LLC*, arguing that an MSO's contractual right to replace a PC's physician-owner may violate CPOM even if the right is never exercised, because the mere retention of the right creates an impermissible division of loyalties. On May 7, 2026, the AG announced a settlement with Aspen Dental resolving corporate-practice-of-dentistry allegations, with first-in-state injunctive terms addressing owner-replacement rights, fee discretion, and incentive compensation. The California Medical Association filed a companion amicus brief in *Art Center Holdings* urging a fact-based, totality-of-the-circumstances approach rather than a categorical rule.

Across all three, the common thread is the AG's scrutiny of the contractual architecture of PC-MSO arrangements: replacement rights, continuity agreements, assignable options, stock transfer restrictions, discretionary or profitability-linked fee formulas, and captive financing, treated as indicia of impermissible lay control. These developments arrive against the backdrop of SB 351 under Cal. Health & Safety Code §§ 1190-1192. Effective January 1, 2026, SB 351 prohibits private-equity- and hedge-fund-backed MSOs from interfering with clinical judgment, declares offending contract terms void, and authorizes the AG to seek injunctive relief and fees.

This is the AG's enforcement position, not binding law

The proposed judgment is a stipulated settlement entered without any admission of liability, subject to court approval, and reached in the shadow of Carbon Health's bankruptcy. It does not adjudicate any issue of fact or law, and it does not hold that PC-MSO structures are unlawful. The *Art Center Holdings* appeal remains pending, and the AG's amicus position has not been adopted by any court. These developments should be treated as significant enforcement signals that indicate the AG's priorities and interpretive posture, rather than as settled California law. What they establish is a clear line between legitimate management support and contractual control over the practice itself, and a demonstrated willingness by the AG to pursue monetary penalties, personal liability, and mandatory restructuring where the AG concludes that line has been crossed.

Next steps and recommendations

PC-MSO structures in California may wish to review the following in light of the AG's posture:

- **Continuity and succession provisions**. Inventory assignable options, stock transfer restrictions, and continuity agreements, with attention to how much control the MSO retains over the identity of a successor physician-owner and whether the physician-owner can exit without forfeiting the practice. Consider limiting replacement triggers to true for-cause events (license revocation, gross negligence, death, or disability) and vesting successor selection in the PC's board or independent physicians rather than unilateral MSO designation.
- **Scope of the management services agreement**. Assess whether the MSA could be read to give the MSO authority over the hiring, firing, or compensation of licensed clinicians, or over other functions that California treats as nondelegable under the Medical Practice Act, Cal. Bus. & Prof. Code § 2052. Governance documents and the MSA should expressly reserve clinical decision-making, coding and billing that affects care, equipment approvals, and physician selection based on competency to licensed professionals.
- **Fee arrangements**. Under California law, an MSO may charge a percentage-of-revenue management fee if the fee is set at fair market value and is not payment for referrals under Cal. Bus. & Prof. Code § 2052. Fees that vary at the MSO's discretion or based on the PC's profitability warrant close attention, as does incentive compensation that rewards clinical staff for product or service sales.
- **Financing**. Distinguish ordinary secured lending on market terms, which the judgment's carve-out preserves, from exclusive, above-market captive financing that functions as a control device. Arrangements requiring a PC to borrow solely from the MSO at above-market rates should be restructured to permit arm's-length financing.

- **Governance and operational substance**. Confirm that unlicensed individuals are not making decisions reserved for licensed physicians and that affiliated PCs have meaningful operational and financial autonomy. Maintain clear distinctions between clinical authority and business services, and audit compliance in substance rather than in contractual form alone.
- **Multi-state platforms**. California enforcement theories frequently serve as a template for other states. Operators with multi-state footprints should evaluate whether California-specific revisions are warranted and whether changes made in California should be reflected in other jurisdictions in anticipation that other states may follow suit on the enforcement front.

Implications for health systems and outpatient clinics

In California, the PC-MSO model is often utilized as part of a health system's outpatient strategy, including through the medical foundation (1206(l)) model, as well as by standalone outpatient clinics. The attorney general's latest signals have not yet directly addressed whether it views these structures differently than the traditional PC-MSO structure (particularly those that are private equity-backed). As described in our prior alerts, our view is that there are material distinguishing factors in light of the health system's/clinic's role in providing healthcare services, and we will continue to monitor developments on this front.

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