



Physician Ventures in the Shadow of Stark – What Options Do We Have?

Hospitals may wish to enter into joint ventures with physicians for a variety of reasons.

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Commonly, the motivation is a mutual desire to bring about a new service line to benefit the communities served by both parties. In addition, hospitals often wish to harness and promote the physicians' expertise associated with the subject matter of the particular service line.

However, if the service in question is a "designated health service" under the physician self-referral law, often referred to as the "Stark" law,^[1] additional concerns come in to play. If the service is not in a rural location,^[2] Stark may preclude the physicians from having a traditional ownership interest in the service. For example, proton therapy facilities are strongly gaining traction in the fight against cancer. However, since proton therapy is a designated health service, the hospital may not be able to put together a "traditional" joint venture where both groups have ownership. In that event, the question is whether other avenues exist whereby the hospital may still engage the physicians in a meaningful way as part of providing the new service.

The reality is that several viable options exist whereby a hospital may take advantage of the physicians' involvement in a service line and give them varying degrees of "skin in the game" without running afoul of Stark. Some examples include:

- Medical Director: The hospital contracts with the physicians to provide the medical director component of the service line.
- Staffing: The physicians are responsible for staffing and providing all professional services at the facility.
- Lessor Joint Venture: The hospital and the physicians form a joint venture that serves in a lessor capacity and provides the building, equipment, or both for the service line.

- Co-management: The hospital contracts with the physicians to serve in a co-management capacity for the service line. This typically involves payments to the physicians for both their professional time spent providing management services, as well as potential incentive payments for helping to generate positive outcomes and cost savings for the service.

Each of these options carries with it certain pros and cons, as well as associated legal issues, which must be vetted as part of determining the ideal relationship. However, they also reflect that the provision of a designated health service does not necessarily present a complete buffer to a hospital's ability to pull in meaningful physician involvement. One of these arrangements may prove to be a desirable option to the physicians from both a financial and professional perspective, while still allowing the hospital to take advantage of the physicians doing more than just utilizing the new service.

[1] The "Stark" moniker comes from the law's primary congressional sponsor, former California representative Fortney "Pete" Stark.

[2] A "rural provider" exception exists under the Stark law which allows for physician ownership of a designated health service located in a rural area. The notion behind the exception is that certain healthcare facilities may not be established in rural areas without physician investment and support. A "rural area" is one that is outside of a metropolitan statistical area ("MSA") as delineated by the U.S. Office of Budget and Management.

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