EPISODE 6.2 | OCTOBER 1, 2025

THE JOURNEY FROM SOLO PRACTICE TO INDUSTRY LEADER WITH SPECIAL GUEST, DR. CYNTHIA MATOSSIAN

David Mandell:

Hello, it's Dave Mandell, host of the podcast. Thanks for joining us. We've got a great episode today. And as we were just talking before we started recording, Jason is our first three-time guest. You can celebrate. So I was looking back as we prepped for this. His last episode was in season three, so we're in six now. And then he was there in season one as well. So the last two topics are really good and this one today we're going to focus on compensation models. And I think any doc who's part of a practice who's not employed by a big institution, who's part of a partnership or a corporation, et cetera, is going to have their ears and eyes tuned because compensation models, whether it's a law firm as Jason knows, or a financial firm like mine, everybody wants to understand how they're getting paid.

Is there a way for them to get paid more? Is there a fairer way to do it, et cetera? And these are all things we're going to talk about in terms of a medical practice. So let me tell you about Jason and then we'll start our conversation. So, he's a healthcare business attorney at the law firm, Benesch, in Chicago. He regularly represents all types of physician group practices, ancillaries of every kind, academic medical centers, post-acute care facilities, lab companies, healthcare information tech companies in M&A, in joint ventures and accountable care and capitated care arrangements and

syndications and compliance issues, all of that stuff. The business of medicine. He's been consistently recognized as a leading lawyer by Chambers USA and he is a former president of the Illinois Association of Healthcare Attorneys where he also served as a member of its board of directors for many years. He has served as the editor-in-chief for Health Care Law Monthly, LexisNexis Publications. So a lot of great experience and a good guy. Jason, thanks for coming back.

Jason Greis:

Well, thanks for having me. Really appreciate it.

David Mandell:

So, in the past we talked about legal issues, working with a lawyer. We talked about ASCs, everything you ever wanted to think about ASCs, we talked about sunsetting partners. I thought that was a really good episode. So, for those of you who that's on your mind, meaning how do I retire in a way that makes sense or how do we sunset other partners, go back and look at that. That was I think a season three, but today we're going to talk about comp models and just how partnerships work today. So let's start with that big picture. What does it mean to be a partner in a physician practice today? How has that changed over the years you've been helping physicians as an attorney?

Jason Greis:

Yeah, I appreciate it. It has changed a lot even in the 20 or so years that I've been doing this, and I think the trend and that shift in terms of what does physician partnership look like and what did it look like back in the 80s and 90s has changed drastically since then and there's been a generational shift more than anything else. Obviously, there's a tremendous dearth of new grads and certain areas of the country and in certain subspecialties, tremendous unevenness around the country. But more than anything else, I think the thing that's changed the most is the younger generation, I won't refer to anyone as X, Y, Z, whatever, younger physicians are just generally more comfortable with an employment model, and so they're looking to health and hospital systems, they're looking to alternative forms of employment and

whereas the older guys like me, I'm not a doctor, but any one of my ilk and older, they wanted to come out and they wanted to be their own boss and were willing to take the risks.

And quite frankly, the risks weren't as great as they are today. It didn't cost as much to start up a practice, and the overhead wasn't as great. But young doctors are just generally asking the question and it's a great question to ask, what does it mean to be a partner in a physician practice nowadays? And you got to be ready to answer that question and if you stumble over it, they're going to know that maybe there's some issues there. Maybe it's not all that it's cracked up to be, but it's really important. I think a lot of practices are struggling in answering that question, what does it mean to be a practice or they answer the question, but it's not resonating with the younger generation in terms of is this something that I want or am I okay going to the local health and hospital system to become an employee doc?

So you got to be ready and you got to think about it starts with your recruitment right out of fellowship or whatever, and you've got to create what I refer to as a compensation ladder where someone comes out and you're at the first rung of the ladder and as they progress through the compensation model, the comp and I use comp liberally, comp and benefits increase. They get better so that there is some incentive for the younger physicians to say, "Hey, this makes sense. I get to make more money, I have more opportunity for advancement as things progress." So, things to talk about when you get that question of what does it mean to be a partner? More generous compensation package, hopefully a seat at the table for decision-making, possibly. Distributions of net profits or dividends at the end of the year. A lot of practices kind of take everything out at the end of the year possibly depending upon your comp model. If a practice is interested in selling, maybe a share of the sales proceeds, it's important to explain that to someone.

But they also need to understand it's not a free lunch and that it comes with responsibilities, administrative responsibilities, potentially signing personal

guarantees. So, I think you've got to give some thought to folks who are coming up through the ranks and when you're ready to have that sit down with them of what does it mean to be partner? You got to have that answer in front of you.

David Mandell:

So, it sounds like for docs who are running a practice where they're going to need to recruit young docs coming in, everything you said was extremely important and relevant and it's really answering the question, "Why? Why would I want to be a partner?"

Jason Greis:

Why? Exactly.

David Mandell:

"What's in it for me essentially," right? I mean not being in a negative sense, but why would I do this versus just a W-two where I don't have any of the headaches or risk and I can get paid. Now, part of that I would think, at least traditionally for folks like us and older is that at some point you're going to make more in the partnership track than you would at W-two. The W-two or the employee model might, you might have a higher pay initially. Oftentimes that's like a steady up into the right maybe cost of living or set increases and maybe that's tied to production, et cetera. But hopefully the partnership overcomes that at some point, right? And that's the why you are willing to buy in, that's why you're willing to maybe sign a personal guarantee, et cetera.

Do you have practices, and I'm guessing is the answer is yes, but it may be only larger practices where they have the ability to offer both like, "Hey, if you want to come in and just be a W-two, we can do that, but here's why you wouldn't want to be on the partnership track," et cetera? Is that something like a two-part bottle and is there a certain size where that can make sense or in small practices it's like, "Hey, we need these people to become partners at some point, so we don't really have the employed only opportunity at our practice." Give me a couple thoughts on that.

Jason Greis:

Yeah, it's a great question and the answer is we are seeing practices shift their model from a two-tiered partnership structure to a three-tiered partnership structure. And that's been a lot of the work I've done with practices over the last five years and there's nothing necessarily novel about the approach. It's the law firm approach. It's the accounting firm approach. It's any professional services firm approach other than maybe medicine historically, where what a number of practices are moving to large and small to account for and to overcome the issue of this question of younger doctors asking what does it mean to be partner or to give more opportunities for different structuring is a three tiered model where you start off as an associate physician, you move to call it a non-equity partner physician, and then potentially to an equity partner physician.

Again, creating different tiers of opportunity, but also that middle non-equity partner rung of the ladder helps to overcome the issue that you're describing, what if I'm particularly risk averse or what if it's just not attractive enough for me to want to make the investment, make the buy-in? The answer is that's fine. You'll be a non-equity partner you'll be at this rung of the ladder. There's nothing wrong with it, but if you want the reward comes with the risk, but if you don't want that, then there's this middle rung for you.

David Mandell:

Yeah, yeah, that makes sense. I mean you and I know it from law firms, pretty popular there and it is good that practices are adapt. So what would you say broadly are some ownership comp models that are working and obviously maybe part of that is this three-tiered structure where there's employed non-equity and equity? What are practices thinking about? What should the people watching or listening to us be thinking about in terms of where things are at today in terms of comp models and partnerships?

Jason Greis:

Yeah, I think we're seeing more of these three-tiered partnership structures, increasingly associate non-equity equity partner it just provides for this kind

of generational shift. Other things that we're seeing work well is really based upon macro change in practice bias. It used to be quite common in the 80s and 90s that you'd have a really big dollar buy-in to a practice and you'd have a large dollar buy-in on the way out. Well, you don't see that anymore, both because physicians are laden with debt when they come out and the economics of physician practice isn't the same as the 80s, 90s with HMO and commercial payer arrangements. So, practices that have a large dollar buy-in and buy-out are struggling and a lot of them are looking to explore changing their partnership model, especially where you have a bolus of partners who are coming towards the end of their career and the practice is thinking, "Oh crap, what do I do? We've got coming due $2 million in buy-out payments."

Well, you've got a couple of choices, you can change your model, but of course people may not be happy about that because they could be counting them on that money afford to fund their retirement, which really leaves you with two options to go out and get a loan to fund those buy-outs or to explore potential sale to private equity to help fund those buy-outs, both of which we're seeing some of that occurring. But to answer your question of what's working well, we've seen a move to a low dollar value buy-in and buy-out model, whatever low dollar value means in your particular market, and it really is market-specific or moving to some sort of sweat equity or model for the buy-in either... The answer is you don't pay a buy-in or the first 2, 3, 4 years after you're made a partner, it results in a reduction in your compensation. And so doctors don't feel it the same way. It's not quite sweat equity, but you also don't have to go out and get a loan.

David Mandell:

Got it. Yeah. Well certainly the financial elements, the lenders that are there, the private equity, you want to, I think if you're a practice, understand what the options are.

Even if you end up saying, "You know what? If it ain't broke, don't fix it." Meaning maybe it is working, maybe relative, someone's watching this and relative to their marketplace, it is fairly low already. Maybe they've made that change over time, et cetera. But I think it's worth revisiting from time to time just to say, "Hey, are we where we should be relative to the market if we're going to continue to recruit people?" Or look ahead, "Hey, we have three docs in the partnership out of eight who are going to be retiring within this five years." We need to think this through not a year before they retire, right? I mean we got to get ahead of it and say, "I'm on it," and this gets back to our topic from a couple of years ago, exiting partners, but let's check in from time to time.

Even if there's no problem today let's make sure that we are maximally positioned for exits, for recruiting, taking advantage of what's out there maybe in terms of private equity or loans, et cetera, so that we know where we're at. It's an evaluation of status quo and could we be tweaking things to be better rather than being, I guess you would call that proactive rather than being reactive, "Oh, now we need to recruit a couple docs because a couple just left," or we see two or three in the retirement mode in the next couple of years, what are we going to do? We owe them, like you mentioned a buy-out. So when I'm hearing this, I'm thinking, "Hey, this is something that practices should be proactive about," checking in, reviewing and just making sure they're in the right place given it's a changing market.

Jason Greis:

There's also a baked-in assumption I think in the discussion of physicians having an intrinsic thought in their mind of what their practices are worth and there's a lot of misinformation and a lot of incorrect information. The simple answer to creating a buy-in, buy-out model if you're thinking in those terms is it depends on who the buyer is. If you're selling equity to a physician or versus if you're selling your practice to your local hospital system, or if you're selling your practice to private equity, those buyers are willing to pay drastically different purchase prices for your business or a piece of your business, whereas private equity may be willing to pay multiples of earnings. Your physician who's buying in as a 10% owner doesn't look at your business the

same way. And so if you are saying to a young doctor, "Well, I can go out to private equity and they're willing to pay X for this," well then the young doctor being recruited has got two choices or three choices.

He says, "Okay, go do it. I'm not willing to pay you that much for your business," or you actually get them to pay that much for the business. But if I were a younger doctor, I'd say, "Okay, where's the guarantee? How do you know that your business is going to be worth this? How do you know you're going to be able to transact for that multiple?" So just keep that in mind if you're thinking about having those discussions, if you're thinking about the value of your practice. A practice-to-practice physician sale, for most small to midsize practices, practices with less than five physicians, there really isn't a whole lot of intrinsic value except maybe to private equity. You're going to transact it between 0.75 - 1.25 times EBITDA to earnings, essentially one year's worth of net profits versus private equity, which can look drastically different.

David Mandell:

Because they're buying the whole business, they're integrating it typically with a whole platform. So there's going to be savings. I mean, it's a whole different thing than, "Hey, come in and buy 5%, 10% of this practice that isn't going to change at all. That isn't going to lay people off, that isn't going to be part of a larger transaction have it," it's just it is what it is. So that makes sense.

What different comp models existing and then trying to get docs to think about changing it, meaning if there's a common pot model like the whatever, we all, seven of us, we all work and then we split a seventh of the profits versus productivity incentive models where I work more, I get paid more, you work less, you get paid less, et cetera? Have you seen practices move between the two and what motivates them and what are some of the objections and how do you overcome them? Maybe you could comment on that and if it's going from common to productivity more often, start with that. Maybe you never see it the other way. I don't know. Just give me an idea of what you've seen.

Jason Greis:

When practices are exploring, revisiting their organizational structure and their partnership structure there's really three different stools or three different areas of the stool. Legs to the stool.

David Mandell:

Legs, yes.

Jason Greis:

They look at the buy-in/buy-out, they look at oftentimes the tax treatment of their company, and then the third is compensation. The tax treatment. So many older practices are C and should they are going to S and the benefit of doing it and how long it takes in terms of the five-year grandfathering. So that's another thing. But then the third and probably most important aspect is compensation.

And there's really three comp models. There's the common pottf as you described it. There's an eat what you kill or productivity-based model or a hybrid model. We've seen practices for the most part that are on common pot where you all throw it equally into the kitty and then you share, moving strongly to an eat what you kill model where you are getting paid some percentage of your net collections and the remainder gets thrown into the pot for overhead costs and expense. And then if there's anything left over at the end of the year, it's paid out in the form of a dividend and distribution. We've seen a strong movement to productivity model because there's an underlying objection of common pot that we're increasingly seeing is that it disincentivizes high producers from wanting to work harder and that there's a feeling of unfairness that high producers are supplementing the low producers or physicians who are moving towards the tail end of their career.

Common objections that we oftentimes hear to moving to productivity-based model are, "We're unique somehow and it won't work in our market." And oftentimes we find that unless the market is truly unique in some strange

way, that moving to productivity more often than not works just fine. The only case that I've seen, and there's a way to deal with it, is if you've got a tremendous amount of payer variability in your geography where let's say north side you've got tremendous number of Medicaid patients, south side is all high commercial pay. Well, there's got to be a way to address that in terms of productivity and fairness, and oftentimes it's some sort of formulaic hybrid approach to it. But we've seen most practices move to an eat what you kill productivity-based model. There are legal considerations, fraud and abuse considerations associated with the Stark Law that it's important to understand if and when you do move to a productivity-based model.

David Mandell:

Yeah, it makes sense to me. I mean, that's why I hedged the question because I didn't think you'd see a lot of people going from productivity to common. I mean, it just seems like once you're used to, hey, having some true revenue skin in the game, I can't think of any reason why you would want to go to something where everybody makes the same. Because like you said, again, we're not going to generalize on generations, but if someone wants to join a practice and just not kill themselves, why should they get any resentment from their partners? "Hey, I'm going to just do this. I'm going to do my nine to five and I'm going to do a good job for my patients and my patient's going to like me and I'm going to have a good brand, but I'm just not going to take call all the time and kill myself. And you can Jason, and you can make that extra money and that's good for you and good for me," I mean, you have to have that kind of flexibility it seems to me today rather than assuming everybody is one or the other.

Because if there is a variability among a group, even from two docs and more, then there's going to have to be resentment if you don't do it that way. That's the way human nature as I understand it, I just don't understand.

Jason Greis:

I mean, it's again, another one of these generational shift issues. Do you value time, money, time or money more? You can't have them both, right? If you

want to make more money, you're going to have less time. If you want more time, you're going to make less money. Productivity-based comp is the fairest way to get you there, whatever the right answer is for you.

David Mandell:

That's right. That's a good way to, perfect way of saying it. So what are some symptoms that you see in a practice when you're talking to partners or practice managers or et cetera, CEOs, et cetera and you say, "It's probably time to revisit or maybe modernize your comp model." What are some things that you start to hear from clients to say, "Hey, there's an issue here. We probably should be addressing it." How does it come up to you?

Jason Greis:

Yeah, there's typically four or five ways where this issue comes up where I mentioned before you have a critical mass of doctors nearing retirement, and you have this epiphany of, "Oh my gosh, our buy-out is going to be ridiculous over the next five years." Those are difficult discussions to have younger physicians asking the question, what do I get as a partner? What does it mean to be a partner? And you're finding that they're taking a pass on partnership for whatever reason. That's also a pretty good indication and maybe time to revisit your partnership structure.

One of the most challenging things that you can do, and I've seen a number of practices struggle with this, and quite frankly a couple fall apart, is where you have too generous a compensation structure upfront for a year, younger physicians such that when they're asking a question, what do I get as a partner? The answer is, you get all the bad stuff. You have to sign guarantees, you're on the hook financially, you've already given away the financial piece of it because it's just the productivity-based model is too rich. So it's important not to create a model that still provides incentive. And then-

David Mandell:

Can we talk about that for one second and then go to the next one?

Jason Greis:

Sure.

David Mandell:

So, you find that where maybe practices in not as desirable areas, and this is what they think they need to do to recruit docs, and then before they know it, they realize, "Oh man, this has some bad knockoff effects." It means that, yeah, we get them to come as a W-two, but they're never going to want to move to the partnership. Is that where you've seen that, where they've been too generous and not thought about it or?

Jason Greis:

Good question. It really hasn't been, let's say in secondary markets or in outlying areas, rural areas, it's really been more of a lack of just forethought. I'll say that.

David Mandell:

Yeah, not financial discipline, not running the numbers, not thinking it through kind of-

Jason Greis:

Yeah, just someone feeling desperation to bring someone in, and maybe it is exactly what you're describing. It's just a recruiting issue and you just have to pay them more, and that makes perfect sense, and you have to account for that, but you always have to be able to explain to someone, "What do I get?" And if the answer is not additional compensation because you're going to be a partner, then what are the other opportunities? Is it that partners get to be involved in maybe some of the ancillaries, whether it's ASCs or dialysis or real estate or research? And in order to be invested and get that investment opportunity, you have to be a partner. You have to create the right mix of carrots, right?

David Mandell:

Yeah, yeah, I get it. Okay. Yeah, so sorry to interrupt. Continue. You're listing some other things come up.

Jason Greis:

Yeah. And then I think in terms of other indications, it's time to revisit the structure is if you're losing doctors or you're losing merger opportunities, you want to merge with another practice and they're just turning up their nose at your partnership structure, obviously that's a really important reason. And then the last one is when practices and their physicians do invest in ancillaries, and what do I mean by that? Labs, surgery centers, dialysis, there are different ways to structure those investments, but if you structure those investments where they are a part of the practice or a sub of the practice, you have to take those into account. Your practice buy-in and buy-out structure is going to change. Whereas if most practices can set the value pretty readily in terms of we value our practice as X. As long as it's consistent from an accounting perspective and your accountant supports it and you're not giving it away, you have a lot of variability and being able to set your value.

But if you have investments that like dialysis and surgery centers, those require a fair market value and buy-out. So now your practice is, let's say it's worth a $100,000 buy-in plus the fair market value of these additional assets that require fair market value. So that's another time where it's important to look at your partnership structure.

David Mandell:

The best practice it seemed there would be to separate those and we've asset protection, et cetera having a separate entity. But what I'm really talking about is, as you were saying, consider them not only, "Hey, this is a place where I can make money in the future," as in the partners, but this is something that should be integrated in our approach to this employee doc, non-equity equity partner, right? Because like you said, maybe your comp is the same, but now you get to participate in the surgery center, and I have clients, you have clients who are the surgery center has been the best thing

financially in their career. I mean, their practice has been good, but they got into surgery center at the right time and the right place and et cetera. And the dividend that's been getting for them for 5, 10, 15, 20 years has been the real kicker.

And that's something that again, maybe the non-equity docs don't get and the other ones do, and there's a buy-in that might be substantial, but that still has a net present value that if we continue to do what they do, they're going to get a real profit level on that too.

Jason Greis:

Right. Makes sense.

David Mandell:

That's another benefit of having these ancillaries. It's not just the income, but it may allow you to integrate it in these comp models and recruit people and get exits, and there's more levers to pull, I guess is the analogy is the way I want to say it.

Jason Greis:

Yeah. Some of the most successful practices in recruiting are the ones that have created these ancillary investment opportunities for their physicians, and given that not all specialty is going to have all of these different opportunities available, but for those that do, it does create a tremendous amount of secondary opportunity.

David Mandell:

Right. Last question. Red flags or things to be wary of. Are there any models that a physician practice should be wary of or things that maybe have gone out of favor and for good reason because it's created some compliance or legal or other issues?

Jason Greis:

Yeah, I think the one that we've really seen go out of disfavor is what I'll refer to as a founder's model where one or more younger physicians signs on with an older doc and the older doc says, "Okay, yes, I will sell you the business when I retire and it's going to cost you $1 million or $2 million." And they're essentially funding their nest egg through the next set of doctors coming up. Like I said, the value of a practice is arbitrary. It's in the eye of the beholder. We've seen a lot of litigation and a lot of bad exits resulting from founders models where doctors, when it comes time to actually pay up and go and get a loan to fund that exit, they either can't or they've reconsidered. Everyone has expectations that are unmet in that circumstance. Doctor's going to have to go out and start all over again, or we'll have to try and put up a shingle in the community.

Maybe there's non-compete issues, maybe there's not. The older doctors suddenly is left without a source of income potentially jeopardizing their retirement plan. So that's one that's particularly tricky and we see a lot of issues around that. And then just more generally buy-in and buy-out structures that are large dollar on the way in and large dollar on the way out. We talked a little bit about that. Another particularly bad model is large dollar on the way in and no money on the way out or you get your accounts receivable on the way out. Those used to be quite common back in the olden days, 80s, 90s. We don't see those as much anymore. If you have either of those two models, it's probably time to start thinking about what else could we do?

David Mandell:

And I want to end on that because I do think in the small practice it's certainly changed. I mean, we've seen things change with private equity, et cetera and in many circumstances for the better, meaning that docs can have other options now versus the, "Hey, I'm just going to have some young doc come in and learn from me two years and then write me a big check." But if you're listening or watching this and you think that's part of your plan or these big buy-ins or buy-outs, definitely reach out to an expert. I mean, I would recommend Jason and start to talk this through because I think ideally, again,

like all this stuff, if you're proactive and you can see an issue in the future before it becomes triage and you're in the financial ER because we've got a problem, that's why you're listening to this. That's why you're reading the books, that's why you're talking. That's why you're proactive and some of your colleagues are not, and maybe some of your partners are not.

So if you're here and you got two partners and you're listening to this, get them to listen to it and watch it because if you want to bring it on the same page to try to be proactive and not only avoid the landmines, but maybe actually do something, that's a win-win across the board. So-

Jason Greis:

Dave, to your point, just in terms of the timing for being proactive, ideally you're starting to have these conversations two years ahead of time, if not more. And if you're thinking about selling your business, whether it's to your partner or to private equity or some other strategic, potentially thinking about them as many five years out. And then getting your business ready for that sale, ready for that exit, cleaning the windows, brushing off the counters, and I'm not talking about necessarily what an investment banker would do. That's actually getting ready for sale. This is more even pre-doing that. So yeah, I agree with you completely. It's important to be proactive and think about these things as far in advance as you can. Easy for me to say in the cheap seats here, because doctors are really busy people, but still something for them to think about.

David Mandell:

I totally agree. Jason, thanks so much for being on. Appreciate it. I know why you're the first to make it to three episodes over six seasons because you always bring great information and real world expertise, you know what's going on out there. So thanks for being back on.

Jason Greis:

Thank you for having me. Always a pleasure.

David Mandell:

For those of you watching or listening, and I imagine most of you're still listening, thank you. In another two weeks, we'll have another episode. If you're so inclined, give us a five-star review, write something nice, tell your colleagues and friends about us. We continue to grow. We hit a hundred episodes in last season, we had over 50,000 downloads. I'm not sure what the number is today, but it's higher. So this is a resource a lot of people are taking advantage of, and so help us spread the word. Thank you.