

**Income Division for Group Practices:  
Structuring Appropriate Physician Compensation Arrangements**

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**I. Introduction**

It may be a bit of a stretch to say that there are almost as many ways in which ophthalmologists in groups can choose to compensate themselves as there are groups—but it's not much of one. Over the years we've been involved in structuring compensation arrangements for thousands of physician groups, and ophthalmologists in particular, and while there are certain broad categories the arrangements fall into, as we'll discuss below, we've been witness to, and helped groups structure a multiplicity of variations on the themes we'll be talking about. That's because how a group compensates its owners, and its employees, says a great deal about that group's history and values, its geography, its payor mix, subspecialty services, age of owners, relative productivity, number of owners, demographics, as well as the particular legal and regulatory challenges the group faces. And, in that regard, while the federal laws that may impact compensation are, in theory, the same for all groups, differences in state laws and regulations may drive groups to address compensation matters differently, and believe it not, enforcement of federal laws varies as does understanding of some of the finer points of federal law. Ultimately, all these factors come into play in how a group ends up where it does in terms of the compensation arrangements it develops. And, while it can be instructive to know how other groups have structured their arrangements, and to understand the broad categories of compensation arrangements we'll be discussing in this course, the arrangement that's right for any one group is, when all is said and done, the one everyone is happy with. There is no inherently "right" compensation model; but there is a right process.

Discussed, then below is the process, and the broad categories most groups end up in at the end of the day. Following that is a brief discussion of a "Pod" or Care Center based model, which we're seeing as ophthalmologists, in response to the continued and growing pressure to be more economically efficient, are now forming larger, regional/multi-location group practices with an eye to gaining a seat at the bargaining table with payors as well as finding clinical and other financial efficiencies.

**II. Addressing Your Compensation Arrangements**

A. *The Fundamentals of Building a Compensation Plan*

1. *The Process Takes Time*

First and foremost, be prepared to commit a tremendous amount of time and resources to building a compensation plan, as it is a major undertaking. Compensation, after all, is a reflection of one's value to an organization expressed in economic terms. That, on its own, is a very emotionally charged and delicate issue. Many professionals like to think that they are the most valuable player on whatever team they happen to be on. In addition, most individuals and groups tend to look at the "value" issue in more than just economic terms. Therefore, dealing

with this issue carefully is very important to a group's survival. Accordingly, from the beginning, there must be a firm commitment to the expenditure of both time and resources (hiring the necessary consultants and using your staff) to get this job done. Failing to manage this has created a great deal of hostility and acrimony among groups leading more than one group to break up over it.

Among other things, it will be important to gather data. No discussion about money can take place without a clear understanding of the underlying economics of the practice. That means making sure that one has information on the numbers of patient encounters for the practice and each individual physician, the numbers and kinds of cases and procedures being performed by the practice and each physician, case rates associated with those procedures as well as the costs of those procedures, the relative value units associated with the various patient encounters and procedures, the charges, and finally, the collections for those services. It may also be important to have an understanding of the demographics of one's practice as well as an understanding as to how evenly the patient population is distributed among a group practice.

All other things being equal, one cannot have too much information in dealing with the thorny issue of building a compensation plan. The secret is to not get lost in the information but, rather, ensure that the relevance of the information is understood. Relevance, however, is determined by understanding what the contributions are that lead to a practice's success and what, exactly, a group wants to foster in the way of behavior.

Thus, for example, a group might believe that it is important, as part of its overall philosophy, to perform charitable works for the community even if such charity does not, in a direct sense, profit the practice. If that is so, it will be important to gather information on the relevant efforts of the individuals in the practice with respect to those "community" efforts. The problem is, however, that those efforts will not translate into profit for the practice, and yet, the way the group will reward those efforts is with the existing profit stream from the practice.

As noted above, in addition to the commitment of time and resources and the gathering of data, it is essential to understand first how a practice defines success, and then what leads to success. For the most part (putting community or charitable efforts aside), most groups define success in terms of the economic benefit the individuals see in terms of their compensation, retirement plan benefits and other fringe benefits coming from the practice.

## 2. Understand the Factors That Lead to Group Success

What leads to economic success? Typically, we see four categories of contributions that lead to such success--1) productivity; 2) executive or administrative efforts; 3) clinical quality; and 4) seniority or other special qualifications.

Production--that is to say the economic impact of actually seeing and treating patients tends to be, far and away, the item that most groups will look at first. It is important to note, however, that productivity can be defined and measured in a number of ways.

For example, production can be defined as charges for one's services. A group, having decided what it believes a particular service is worth (as evidenced by its fee schedule), then determines relative productivity, comparing each physician's charges for services within the

group to the others'. The trouble with this approach is, obviously, that charges in today's world bear no relation to the money ultimately received for those services. Thus, is it really "fair", if looking at production, to credit an ophthalmologist with \$2,000.00 in charges for performing a cataract surgery that pays only \$600.00, when an office visit might be charged out at \$80.00, but which is, ultimately, reimbursed at, perhaps, \$60.00 or \$65.00? The collection percentage for the one might be no more than 30% of charges, while for the other it might be as high as 80%. Looking solely at charges to determine production may skew compensation in favor of those who are high producers, not in terms of actual revenues, but in terms of inflated charges. Moreover, one might argue that, in favor of looking at collections, the only important aspect when looking at production is, in fact, the dollars which come through the door.

If revenue generated is, indeed, to be the yardstick for measuring production, it would seem that looking at dollars collected is more appropriate than looking simply at charges. Certainly looking at dollars collected solves the problem of skewing compensation in favor of those who charge a lot but cannot collect a lot. On the other hand, if what is meant by "production" is something different than revenues directly generated--e.g., production defined as either volume of patients or numbers of procedures, looking at collections alone may prove problematic. That is to say, there are some groups where the individual physicians each perform similar numbers of office visits and surgical procedures, but the payor mix among the physicians in the group is dramatically different. For example, one physician might handle a patient population which is represented largely by commercial carriers and Medicare, while another within the group is doing more Medicaid and similarly less highly compensated work. Each of them "produces" similarly in terms of the volume of patient encounters and surgical procedures; however, there might be startlingly different levels of collections for each such physician. Indeed, looking at production as only dollars collected could be divisive--causing a scramble for the better paying patients, leaving the less well paying patients unattended to.

Some groups define production in terms of the relative value units ("RVUs") produced by each physician. Defining production in this fashion takes care of the concerns of over defining production by virtue of charges and collections, but in some fashion creates its own concerns. Defining RVUs for the various patient encounters and surgical procedures is, relatively speaking, time consuming and labor intensive. Keeping track of those RVUs also requires a commitment to track such data.

Still other groups look at the number of patient visits or encounters as a means of measuring production. This is particularly true where, for example, a group might have someone who has become purely a medical ophthalmologist and whose job it is to, as it were, screen the patients for treatment by the other surgical physicians within the group. By looking at patient encounters as a measure of production, an individual whose charges and collections might be lower than everyone else's (because office visits pay less than do surgical procedures) and, similarly, whose RVU production might be low, can nevertheless do quite well. And, if the group wishes to encourage such a division of labor because it is more efficient, for example, for one person to be handling all of the medical office work, while others do the surgical work, then as a result this can promote greater cohesiveness and feelings of solidarity.

Finally, one can look at defining production not just in terms of any one single element (e.g., charges or collections). Rather, one can define production in terms of any combination of all of the above factors--looking at charges, collections, RVUs and visits and/or time spent in the office, and weighing each of them to determine one's relative production. The key, as we will

see below, is having an understanding as to just what behaviors the group wants to encourage and promote.

Apart from productivity, there are other factors that can lead to practice success. Among them are executive or administrative efforts. These may not lead to a direct result of dollars flowing into the practice; however, they can be, and frequently are, extremely important. For example, management by one or more individuals in medical practices is frequently given short shrift both in terms of actual performance and in terms of compensation for such performance. The fact of the matter is that most medical group practices have succeeded in large part in spite of failing to pay attention to the importance of such efforts and compensating them appropriately. However, in today's incredibly competitive/managed care environment, executive efforts are becoming increasingly important in determining the overall success of ophthalmic practices. These efforts include, among others, the day-to-day management (budgeting, controlling expenses), contract negotiations, networking and referral building and the like. The problem is, obviously, that it is difficult to ascribe the direct dollar value to most of these efforts, but the fact is, in today's market, without those efforts, many practices would fail.

In addition to productivity and executive/administrative efforts, clinical quality is a factor that leads to a practice's financial success. After all, without such an emphasis on quality, a practice can, at the very least develop a very bad reputation--which, ultimately, can lead to a loss of patients, referrals and revenues. In these post Affordable Care Act days, though, there is more and more emphasis on gathering and reporting patient outcomes, and pay for performance shared savings plans are building, with greater specificity, reimbursement models that measure and weigh outcomes in ways that tie directly to payment. Groups do need to be planning for this. If bonus monies are going to be made available, or if over-utilization or poor performance leads to penalties, how will a group, with an outlier go about compensating, through bonus or otherwise, the people who contributed to the gain or loss?

Finally, seniority or special qualifications (e.g., fancy credentials) can often lead to or can assist in contributing to practice success. The very longevity of certain individuals in practice contributes to a greater sense of strength and stability and, in many cases, leads many referral sources to continue their referral patterns. This cannot be overstated. The presence of a "senior statesmen" physician in a practice can be a big contributing factor to financial gain. Similarly, someone with stellar credentials--e.g., having graduated from an ivy league school, having published a number of articles or, otherwise, being seen as an "expert" in a particular area, will often lead to increased referrals and, as a result, increased revenues.

### 3. Reconcile Group and Individual Goals

Once one understands what the contributions are that lead to practice success and a group has agreed upon those contributions, there must then be a reconciliation of personal, as opposed to overall group goals. Individuals will be, more than likely, motivated to maximize their own financial well-being as opposed to that of the group. However, it is the group's goals that must take precedence. Thus, a group may want to foster production, but a compensation model that relies solely on production (as defined, for example, by dollars collected) might create an environment that is far too competitive. Such a compensation model might pit individual physicians against one another in an attempt to get better paying surgeries and procedures, thereby creating an atmosphere of rivalry, rather than camaraderie. On the other hand, an income division model that does not, in some fashion, promote production may

lead to certain individuals cutting back on their workload and allowing others to do more than their fair share of work.

In determining the type of compensation plan to develop for your group, the solution, if one can be said to exist, is to define the values of the organization and create a collective “corporate culture” where one may not have existed.

#### 4. Define Practice Income

Next, on a practical level, it is most important to define practice income. That may seem fairly easy and for the bulk of the revenues flowing through an ophthalmic practice, there really isn’t much of an issue. Practice income, obviously, incorporates revenues collected from patient encounters and procedures, co-payments, capitation payments, quality bonuses, and revenues from ancillary services such as optical shop and similar revenues. On the other hand, many groups allow their physician members to act as expert witnesses in civil litigation matters for which they receive remuneration. Other groups have physician members who write and publish books and articles for which they are paid, while still others have members who teach and receive stipends for such teaching. Others perform administrative duties for hospitals, IPAs and the like, and receive remuneration for those services. Finally, others invent and create devices and systems that generate royalties and other monies.

It is imperative that groups look at any of these situations and make a determination as to the extent of which such items need to be included in the definition of income. In our opinion, anything related to the practice and which might have either a beneficial or potentially detrimental (if things go wrong) effect on the practice is something that should be included in the definition of practice income. Obviously, if a particular revenue stream is to be included in the definition of practice income, there must be a corresponding way of compensating those individuals who generate it.

#### 5. Determine Net Income for Division

Just as important as defining practice income, is defining physician income or “Net Income”, for those members who will be sharing income. In most small to mid-size groups, one cannot look simply at W-2 income as the measuring stick. Physicians find ways to pay themselves from the practice beyond, simply, their salaries. For example, most physician group practices have some form of a retirement plan for the physicians as well as other fringe benefits and “semi-personal” expenses (automobile expenditures, CME to exotic places and the like). For most small to mid-size and even somewhat larger groups, it is important to recognize that all of those items constitute physician income that is to be shared. Essentially, whatever is not paid as “true” overhead is to be considered physician income.

#### 6. Ensure Legal Compliance

In devising a physician compensation system that defines and encourages productivity, it is crucial that such a system complies with all applicable laws. In particular, careful attention must be paid to federal laws, including the physician self-referral law (better known as the Stark law) and the Federal anti-kickback statute. Group practices must also ensure compliance with state anti-kickback statutes as well, because while the Stark law and the federal anti-kickback statute apply only to services covered under Medicare, Medicaid

and other federal health programs, the state statutes may apply to services covered by all insurance payers.

When a physician group begins analyzing compensation arrangements, the focus is, of course, on the money and how it is to be distributed. Many times, a practice will formulate a plan and neglect to take into account how the Stark law and other laws significantly limit the way income can be divided among the group. The Stark law basically prohibits physicians from making referrals to an entity in which they have an ownership stake, receive compensation from or have any other financial arrangement with for designated health services covered by Medicare or Medicaid. The designated health services generally applicable to ophthalmic practices are those for certain radiology and imaging services, specifically A-scans and B-scans, and OCT photography. Practices, however, should regularly check for updates to which CPT codes are classified as designated health services to ensure continued compliance. See [https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List\\_of\\_Codes.html](https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html).

The most overlooked or misunderstood part of Stark is that it **does apply** to what happens within your own practice, unless covered by a clear exception. In addition to barring physicians from making referrals for the above services, the Stark law also prohibits compensating a group practice physician for referring patients for *designated health services* (“DHS”) to any physician or staff member in his or her own practice. Therefore, a group practice should be careful in how it allocates practice income within the group in terms of productivity. However, as long as compensation is not directly related to a physician’s volume or value of referrals for designated health services, group practices may pay a physician a share of the group’s overall profits derived from such services. For instance, the overall profits of a practice may be equally divided among physicians or divided in a similar manner as profits for non-designated health services (e.g., productivity as measured by non-DHS referrals).

Another permissible way to distribute income to physicians in the practice is to pay or give production credit to a physician for designated health services he or she personally performs or services performed by others that are incident-to those services. A service is considered an incident-to series if it does not have its own separate and independently listed benefit category. Be aware, however, that certain services such as x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including A scans and B scans) have their own benefit category and are not incident-to services. However, the in-office-services exception to the Stark law allows physicians the opportunity to receive credit for performing the professional and technical, if performed by the physician and not by a staff member, components of diagnostic tests otherwise classified as designated health services if all of the requirements of the exception are met.

Although the Stark law provides some guidance and exceptions regarding physician compensation, it and the other federal and state healthcare statutes and regulations remain very complex. A group practice needs to be aware of the frequent revisions and updates to these rules in order to make sure it remains in compliance. Therefore, it is advisable to have a health care attorney review any compensation arrangement that is being considered before implementation.

## 7. Keep It Simple

Once a physician group has gone through these steps, it can then begin the process of “modeling” a compensation system. It is important to keep in mind, however, that the simpler the system, the better. Every system needs to be perceived, ultimately, as “fair” by all of the participants. However, while fairness is one of the goals, it cannot be the only goal. All participants must understand that there is no such thing as a “perfect” compensation system. Any system can be “gamed” and, in some circumstances, results can be achieved that seem otherwise less than entirely fair to someone in the group. The key is, on the whole, to achieve a balance of fairness, while developing a system that is simple enough to administer. If a compensation system is too complex, there ultimately will be disputes, which, in the end, will result in expenditures of time, effort and money far in excess of the value of the issues actually involved.

#### 8. *Begin to “Model” Systems*

The next step is to develop “model” compensation systems. That is, in conjunction with the group’s advisors, systems need to be fleshed out and tested – seeing what the results would be under each of the different models, based upon current and historical data. In that manner, systems can be compared one to the other, based upon existing data and hypothetical variations of the same.

Once a group begins to create “model” systems, they should look to spending somewhere between 3 to 6 months in that process, during which time the different models are tested, discussed, compared and, ultimately, decided upon.

#### B. *Options - Different Models To Consider*

A key component in the reassessment and evaluation process is for group members to understand the various models and alternatives that exist. There obviously are a myriad of different compensation models that are presently being used by ophthalmologic groups throughout the country. There are, however, a few basic models that are commonly seen, whose basic components can be helpful for groups in the evaluation stage.

#### 1. *One Hundred Percent Equal Allocation*

Under this approach, 100% of the available practice “net income” (e.g., what is left after all expenses have been paid, for the owner/partners to take as salary, bonuses, retirement plan contributions, dividends and certain agreed upon semi-personal expenses) is allocated equally among those members sharing in the arrangement. Groups that utilize an equal split successfully for a long period of time tend to attribute its success to a strong sense of “trust” amongst its members. In these practices, there is also a great sense of being part of a “group practice”.

The members in these groups also tend to produce (however production is defined) at approximately the same level, or, if there are significant differentials in production, there is a recognition that there are different kinds of contributions that lead to the overall success of the group practice. Thus for example, a medical ophthalmologist in a multi-specialty practice likely will not have the same production numbers as, say, the retina doctor or the cataract surgeon, but he is appreciated and thus compensated for his contributions, production, referrals to others in the group, reputation in community, etc. Or, it could be that the group recognizes non-

revenue producing contributions such as administrative responsibility, hospital positions, academic positions, etc. Most groups that do split the income on an equal basis typically are concerned about the negative side of a production-based arrangement in terms of it creating unhealthy competition, which could undermine the group's overall goals and objectives.

Some groups that use 100% equal income division will often, nonetheless, automatically adjust the equal arrangements if a member's production decreases too significantly by implementing certain trigger mechanisms or a "threshold production level". For example, a group might agree that if a member's production falls below 75% or 80% of the average production of the other members of the group, then his or her income share might automatically be calculated in part, or even entirely, on production. The idea is to establish, at the outset, certain standards in order to avoid an uncomfortable confrontation when a member's production falls off significantly, for whatever reason. Groups that use and maintain a successful equal income split will often run various production reports for its members to track the data. This data is helpful in the sense that it can continue to confirm that production has remained relatively equal despite perceptions to the contrary. Additionally, the data provides an early indication of possible problems, which can then be addressed before they develop into a significant problem.

## 2. One Hundred Percent Production Allocation

A good number of ophthalmologic groups adopt an income allocation formula that is 100% based on individual production. The approach is fairly straightforward in that, at least theoretically, the harder one works the more money he or she will make. The emphasis in this method is on meeting patient demands and providing the clearest of incentives for group members to be productive. (As stated above, groups should be very careful in defining what is meant by "productivity"--i.e., whether it means charges, collections, RVUs, or some combination of those items.) A productivity approach also embraces the concept that the more productive the group members are, the more successful the overall group will be.

Then again, a productivity approach may also create unhealthy competition among ambitious owners for available work. This, of course, is not the case in all groups, and the potential for a negative outcome really depends on the individuals within the group. However, groups reevaluating their compensation arrangements need to be cognizant of this potential.

Basing a group's compensation entirely on a production basis disregards those significant other contributions which are so integral to a group's overall success. For example, time spent by a group's managing partner, unless separately compensated, is not recognized under a pure productivity split. Indeed, it penalizes that member's management responsibilities, as such responsibilities take away from his production time. In recent years, heavily production based arrangements have come as, generally speaking, inappropriate in a managed care environment, since the emphasis is on more care rather than appropriate care.

## 3. Two-Tiered Allocation

Probably the most common format for ophthalmologic practices is the "two tiered" approach, whereby a portion of the practice net income is divided on a production basis and the other portion is divided equally. Under this methodology, groups attempt to gain the benefits of both the production and the equal income split. In this manner, each member

has a strong incentive to make the overall group as successful as possible (regardless of which doctor actually sees more patients or performs more work). He or she also has a personal incentive to produce. Since both group loyalty and individual ambition should be well accepted as desirable attributes, the formula combining both the equal and production components may be a workable solution. Variations on the two tiered combinations are limitless. For example, some groups divide 50% net income equally and 50% on a production basis. Many ophthalmologic group practices utilize a greater production split, perhaps 70% or 80% on a production basis, and the balance being split on an equal basis. Where a group practice has maintained a fairly individualized practice, a greater production allocation may make sense. The right allocation for a group will depend upon the culture and philosophy of the group and the individual members making up the group.

#### 4. Multi-Tiered Approach

Under the multi-tiered approach, groups can establish a tier or tiers in addition to the production and equal allocation. For example, contributions such as management and administration and outside activities that benefit the practice (*i.e.*, quality, seniority, credentials, teaching and speaking), can be taken into account. In so doing, however, the group must determine both what contributions lead to practice success (besides production), as well as which activities the group wants to promote or encourage its members to engage in. In addition, the group must then agree upon the weight it gives to each contribution or "tier". The greater the number of activities and contributions that are recognized, the more difficult this system will be to administer, and groups should try to limit the categories or combine contributions into groupings. Further, the more that is recognized, the more frequently the arrangements will probably have to be revisited to ensure the allocations percentages used for each contribution category makes sense.

#### 5. Base Salary Plus Incentive

This method is similar to the three tiered approach described above. The difference is that the group establishes, in advance, the specific framework and ground rules in a clearer fashion than under the pooled approach. For example, the group might determine that each ophthalmologist in the group can receive a base salary equal to \$200,000. If there is any money remaining after all expenses, including the physicians' base salaries, have been paid (the incentive pool), it would be allocated among the physicians, perhaps in some fashion--looking at production, management contributions, or a combination of these factors, or others. The concept of working with available net income, of course, is the same except, under this manner, the base salary is first established and the members of the group understand that, if there is any money left over, it will be allocated pursuant to the agreed upon incentive allocation. This methodology can be effective if the group is willing to set base salaries at a level that will make the incentive pool large enough to be meaningful. This is often difficult, as group members considering this approach tend to attempt to secure as high a guarantee for base salary as possible.

There are different variations that groups have adopted and have worked comfortably with. In some groups, the base salary will be determined equally across the board for all group members. Thus, members receive a "workers' share", which provides for the fundamental concept that each member of the group will have equal value for presumably certain equal

aspects of their contribution. It will then be the incentive that will be allocated to recognize their other contributions that the group feels are important to reward.

In other groups, base salary is based on a production basis. For example, if group practice overhead is, say, 55%, often each member of the group might be entitled to 35% of his or her collections as their base salary. The balance (which will exist almost by definition) is allocated according to production, management contributions, and other factors. In setting the appropriate percentage entitlement, groups should attempt to ensure that amounts will be available to be allocated under the incentive allocation.

Another concept that is relatively new and has begun to be adopted by some larger groups is the concept of a negotiated base salary. That is, members will have their base salaries set by annual agreement. The idea behind this method is to attempt to evaluate each member's actual contribution to the group. All members should be involved in this evaluation in smaller groups. However, in larger groups, a strong, well-regarded managing partner or an equally determined compensation committee should take responsibility of performing the annual evaluation of the member's contributions, and then make the appropriate recommendation as to that member's base salary for the coming year. The managing partner or the committee can also establish the criteria for measuring the various contributions that will be considered and weighted in the evaluation process.

Of course, this type of negotiated method of determining base salary may not be right for all groups, as it can be extremely difficult to successfully implement. This method requires very specific data as well as the right mix of personalities and individuals that work well together and trust one another in order to create and maintain an equitable process.

Finally, in a multi-tiered approach, some thought should be given to providing for a certain portion of the income pool to be paid out in the discretion of the Compensation Committee or Managing Partner. This allows a group to "fine tune" its compensation scheme by allowing some group representing the practice as a whole to compensate members who have made some contribution to the overall growth and prosperity that their formula might otherwise not adequately address. This can be a difficult method for group members to become comfortable with, since so much may be left to the discretion of others. It does, however, have the potential to recognize and reward those contributions which can be overlooked in the more traditional equal/production income division approaches. It is advisable for groups considering this approach to only allocate a very small portion of the available net income to be allocated on this discretionary basis during the earlier years of the arrangement. As the group becomes more comfortable with this approach, the amount of the incentive can increase as members become more comfortable with the arrangement.

## 6. Cost Accounting

Under a cost accounting approach, income and expenses are separately allocated among group members - treating each individual, in essence, as a separate profit center. On the revenue side, the group will usually look to allocate all or a portion of the revenues on a production basis (*i.e.*, each member receiving credit for his own production or his proportionate share based on personal productivity (however defined) of all the production of the practice). That having been said, however, some groups allocate a portion of the practice

revenues equally to account for equal on-call responsibilities, other contributions, or interests in ancillary revenues.

On the expenses side, a similar analysis takes place. Groups decide which of the practice's expenses will be allocated on an equal basis and which on a production basis. Here, groups will often decide that fixed expenses (*i.e.*, rent, accounting fees, taxes, business insurances, etc.) should be charged against members on an equal basis, while certain "variable" expenses (*i.e.*, supplies, billing, postage, transcription services, etc.) will be allocated on a production basis. Still other expenses (e.g., "semi-personal" expenses, such as meeting and travel costs, cell phone usage, etc.) might be traded separately and allocated directly against the member who measures the cost.

Note that under the other compensation arrangements described above, practice expenses are not separately tracked or accounted for directly as the formulas just allocate the "net income" ("bottom-up approach"). However, even though there is not a separate allocation of practice expenses in these bottom-up approaches, the practice expenses are, in fact, divided in the same way as the net income is divided, since dividing the bottom line (*i.e.*, "net income") automatically divides the upper lines in the same proportions. While often misunderstood, this approach is both logical and straightforward. Under a cost accounting method, however, (often referred to as a "top-down" approach), the group needs to agree as to the specific manner in which the practice expenses (as well as the practice income) will be allocated. From a practical perspective, allocating expenses can be complicated and time consuming. In addition, we have found that the more the group tries to "properly" allocate expenses, the more they are likely to disagree about what is the proper allocation.

### **III. Pod Based or "Care Center" Compensation Models**

In the last few years, we've seen an uptick in the number of groups that want to become bigger, not by "organic" growth (*i.e.*, adding one doctor at a time through hiring), but rather by merger, or something like a merger. In any given market, right now groups are exploring combining their practices to form large single specialty "Mega" groups. In these practice mergers (and we use that term in a loose sense here), often what really takes place is not a merger in the true legal sense of the word. Many times, these are brand new groups being formed while old practices are dissolved, but the groups treat the physicians from each of the old pre-existing group practices as separate "divisions" or "Care Centers" within the new larger group. Each Care Center or division (sometimes they are referred to as "pods") roughly corresponds to a pre-existing practice and operates out of the old locations, employs the same personnel and so forth. The difference is, all physicians and other personnel are now employed by and provide services through the new entity (which is most often an LLC), under the same tax I.D. number, and the new group adopts a common benefits package, has either common EHR software (or the ability to allow systems to "talk" with one another), similar or the same management systems, and the like. Revenues, as they are collected, and expenses are allocated to each of these divisions or "Care Centers" in the same way that cost accounting compensation methodologies described above. The difference is that it is not usually hard to track, since each old group was, as a group, presumably tracking and accounting at the group level already, if not at an individual level, those revenues and expenses.

As commonplace as these arrangements are becoming, a couple of words of caution are appropriate. This kind of "decentralized" compensation/cost accounting does raise Federal

Stark law concerns. This is not to say that these arrangements are “wrong” or illegal. Rather, they do require a careful legal analysis to make sure that the larger, new group is indeed considered a group for Stark law purposes—as well as for antitrust purposes. A detailed discussion about these Mega-Groups is beyond the scope of this course. Suffice to say that, at the “Care Center” or division level, all of the considerations as to how to compensate owners still come into play, and the layering of a decentralized compensation model on top of that makes the discussion more complicated.

#### **IV. Conclusion**

There are a number of variations on each possible theme described above. The important thing, however, is that, ultimately, there is no single “right” way for groups to divide the income “pie”. Data must be collected; input from all affected and from outside sources is required; discussion must take place as to what is considered important; models must be prepared and analyzed; and, ultimately, implementation must occur--which involves reducing everything in the clearest possible terms, to writing, in appropriate legal documents (compensation agreements, employment agreements, board resolutions, etc.) Without the documentation, ultimately the process of changing a compensation plan is meaningless. Finally, a word about making changes--any time a change in a compensation plan takes place, there will be winners and losers. Assuming the same level of net income, any change inevitably will result in someone being better off and someone being worse off. We generally recommend that any drastic changes be the result of a phase-in to allow people to adapt their behavior, **as appropriate**, to a new system. This can take the sting out and allow people to see how some small changes in their behavior and overall growth in the bottom line might leave them better off and not worse off.