Marshall Medical Center
1206(d) Clinics Case Study
Marshall Medical Center

- 105 Bed Community Hospital, located between Sacramento and South Lake Tahoe
- 12 Outpatient 1206(d) clinics, including a R.H.C.
- Service Area - 160,000 people
- High Medicare - Over 50%, Clinics are over 60%
- Nearest competitor is 25 miles West, virtually none North, East and South
- Gold was discovered 8 miles North but we’ve never uncovered any in our construction projects
In The Beginning (1995)

- Major competitors moving into our service area
- Immediately met with all Family Medicine/Internists on medical staff
- Reviewed regulatory options including 1204(a), 1206(d) and 1206(l), RHC and FQHC options
Results

- Chose 1206(d) hospital outpatient clinic
  - Exclusion to primary care clinic requirements of the California health and safety code
  - Highly regulated - Joint Commission
  - Building restrictions - Title 24 and OSHPD 3
  - Better reimbursement
- Physicians formed a medical corporation and contracted with the hospital to provide services
- Built two compliant clinics
- Purchased assets
First Seven Years

- Became safety net for physicians - competitors failed
- Gave a core group of physicians with which to form an IPA and contract for HMO patients
- Lost an average $100,000 per physician
- Struggled to act as a group
- Formed a physician/nurse practitioner model
- Opened practices to Medi-Cal and Medicare
- Developed hospitalist model using rotation of internal medicine physicians
Last Nine Years

- Opened Marshall Peds after 5 physicians retired or left, Jan 2003
- Opened Marshall Ob/GYN after our only female physician left, Jun 2004
- Opened Marshall GI after 5 physicians leave over call issues, Mar 2005
Last Nine Years

- Opened Marshall Family Medicine in El Dorado Hills, Mar 2005
- Opened Marshall Hematology and Oncology as Medicare reimbursement changed dramatically, Jan 2008
- Opened Marshall Rheumatology, new specialty to our area, Feb 2008
Last Nine Years

- Opened Marshall Cardiology clinic after Sacramento group dissolved, Dec 2008
- Currently in discussions with five specialties losing physicians and concerned about recruitment affects to their private practices and upcoming affects of federal health reform.
Advantages to 1206(d) Clinics

- Secure structure for primary care referrals to specialty care
- Secure structure for specialty care referrals to hospital
- Maintains primary and specialty care in our community - our mission
- Allows access and loyalty of physicians in outlying communities to send patients
- Helps maintain hospital outpatient services
- Strong recruitment tool for bringing physicians to our community
Advantages to 1206(d) Clinics

- Vertical integration increases hospital leverage with insurance companies
- Physicians available to serve on committees and projects
- Aligns incentives and loyalty, if the hospital does not do well, the medical groups will be effected
- A strong marketing presence in the community
- Medicare and Medi-Cal pays significantly more to hospital based clinics
- Maintains insurance contract access to the independent physicians
Advantages to 1206(d) Clinics

- Gives access to Medi-Cal and indigent patients to physician care
- Lowers the demand upon the emergency room for nonemergent care
- Less restrictive in trying to support physicians to be able to serve this community for the long term
- Brings the group practice model to our area - including group compensation payments such as incentives
- Medical staff oversight for quality assurance
Disadvantages to 1206(d) Clinics

- Offers little control of physicians
- We are losing $72,000 - $200,000 per physician this year
  Most specialties have lower losses and some are breakeven
- Tough to negotiate a contract with groups
- Very expensive office construction and staffing costs due to being hospital based clinic
- Independent physicians are pressuring to join and some are jealous
- Some write-offs due to the “72-hour” rule
Disadvantages to 1206(d) Clinics

- Expensive to start practice through the first few years
- Many of the physicians we are adding are already in the community so we are not increasing access
- Multiple physicians groups if physicians do not want to partner
Why do our 1206(d) clinics lose $ 

- OSHPD requirements for clinic building will raise the cost of clinic space by up to 100%
- Marshall pays employees a higher salary than independent physicians and provides better benefits
- State licensing requirements such as registered nurse oversight
- Marshall pays all group expenses (accounting, legal, group officers, CME etc…)
- Clinic accepts Medi-Cal versus 0% for many in private practice
Why do our 1206(d) clinics lose $?

- Clinic does not provide variety of profitable outpatient services in competition with the hospital.
- FMV physician salary and benefits are determined by Western region averages which are high compared to El Dorado County physicians.
- Clinics are used as an expansion tool and it takes a few years to fill capacity.
- Marshall does not use the group contract for sole source contracts but requires insurance companies to offer contracts to independent physicians in the community.
- Physician’s requests change completely when it is not their money they are spending.
## Visits Per Provider Per Day 2010

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<th>Specialty</th>
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What is Happening in the Industry?

- Compensation based on quality indicators
- Deja Vu - Hospitals are partnering with physicians and setting up clinics
- Gen X are looking for employment
- Physician incomes are falling, looking for security
- Health care reform
- AB 646, 648 & SB 726 – Start of physician employment in Ca – Complete fall of prohibition?
Follow-up Questions

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