

## Riverside/San Bernardino: Vast Region, Market Fragmentation Add to Access Woes

### Summary of Findings

With no dominant health system operating across this vast region, hospitals and physicians in the Riverside/San Bernardino market remain relatively fragmented. There are distinct submarkets serving diverse populations. The economic downturn hit the area particularly hard, with many people losing employer-sponsored coverage. These two factors led to reported barriers to care for both lower-income people and those living in remote areas.

The region has experienced a number of other changes and challenges since the last study was conducted in 2008. Key developments include:

- ▶ **Improved overall hospital financial performance.** Many hospitals maintain bargaining clout on payment rates because health plans must ensure access in each of the region's many submarkets, some of which are underserved. This has helped maintain and even improve financial performance at the same time that hospitals have struggled with a declining payer mix as people lost private health coverage. Other factors protecting hospitals' bottom lines include efforts to improve efficiency and contain costs, and more recently, funds from a new state hospital fee program.
- ▶ **Increased presence of Kaiser.** Kaiser Permanente's presence has expanded, with other providers — both hospitals and physicians — viewing the integrated delivery system as their biggest competitive threat.
- ▶ **Growing concerns about physician supply.** The Riverside/San Bernardino physician market faces particular challenges given its sprawling geography and weak economy. The per capita physician supply in the region is low compared with other California markets, and some observers reported that demand for physicians continues to outpace supply.
- ▶ **Growing efforts by hospitals to align with physicians.** Physicians remain largely independent in solo or small practices, although some are joining larger physician-owned organizations. Hospitals are seeking to align more closely with physicians — both to gain patient referrals and inpatient admissions and to prepare for new payment arrangements under national health reform. At the same time, as more people get coverage under health reform, physician shortages are expected to intensify.
- ▶ **Increased pressures on safety nets.** County-run safety-net organizations face capacity and financial pressures to care for the growing numbers of Medi-Cal and uninsured patients. Both Riverside and San Bernardino Counties are trying to work more with federally qualified health centers (FQHCs) and other private community clinics and health centers, especially as they prepare for reform.
- ▶ **Slow development of FQHCs.** Market observers note that health centers in this region have been slower to receive federal status and grants than health centers in many other parts of California. State data indicate that

the region has fewer than half the FQHCs per capita than the state average, even with the area's population more likely to be low income and uninsured or covered by Medi-Cal.

- ▶ **Transitioning low-income people to coverage.** Given limited funding in Riverside and San Bernardino Counties, both expect to enroll about 20,000 people in the county's Low Income Health Program under the state's Medicaid waiver. This represents a fraction of those potentially eligible.

## Market Background

Unlike northern and coastal areas of California, the Riverside/San Bernardino region is recovering more slowly from the economic downturn. In January 2012, *Forbes* named Riverside the nation's most difficult city in which to find a job.<sup>1</sup> In another sign of the times, the city of San Bernardino declared bankruptcy in July 2012.

Home to more than 4.2 million people, Riverside and San Bernardino Counties cover a vast geographic area of more than 20,000 square miles (see map on the last page). San Bernardino is the largest county in the contiguous United States and almost twice the size of Massachusetts. Most of the population in the region is concentrated in the cities of San Bernardino and Riverside and surrounding suburbs. Outside of this urban center, much of the region is rural and geographically fragmented. Federally protected land, mountain ranges, and large desert areas divide the population into numerous submarkets, with

**Table 1. Demographic and Health System Characteristics: Riverside/San Bernardino vs. California**

	Riverside/SB	California
<b>POPULATION STATISTICS, 2010</b>		
Total population	4,224,851	37,253,956
Population growth, 10-year	29.8%	10.0%
Population growth, 5-year	9.4%	4.1%
<b>AGE OF POPULATION, 2009</b>		
Persons under 5 years old	7.5%	7.3%
Persons under 18 years old	28.9%	26.3%
Persons 18 to 64 years old	61.6%	62.8%
Persons 65 years and older	9.5%	10.9%
<b>RACE/ETHNICITY, 2009</b>		
White non-Latino	40.8%	42.3%
Black non-Latino	6.3%	5.6%
Latino	43.9%	36.8%
Asian non-Latino	6.1%	12.1%
Other race non-Latino	2.8%	3.1%
Foreign-born	21.2%	26.3%
<b>EDUCATION, 2009</b>		
High school diploma or higher, adults 25 and older	78.8%	82.6%
College degree or higher, adults 25 and older	25.2%	37.7%
<b>HEALTH STATUS, 2009</b>		
Fair/poor health status	16.1%	15.3%
Diabetes	8.7%	8.5%
Asthma	15.3%	13.7%
Heart disease, adults	5.5%	5.9%
<b>ECONOMIC INDICATORS</b>		
Below 100% federal poverty level (2009)	17.0%	17.8%
Below 200% federal poverty level (2009)	38.5%	36.4%
Household income above \$50,000 (2009)	47.2%	50.4%
Unemployment rate (2011)	14.7%	12.4%
Foreclosure rate* (2011)	6.8%	n/a
<b>HEALTH INSURANCE, ALL AGES, 2009</b>		
Private insurance	51.2%	55.3%
Medicare	8.1%	8.8%
Medi-Cal and other public programs	21.2%	21.4%
Uninsured	19.5%	14.5%
<b>SUPPLY OF HEALTH PROFESSIONALS, PER 100,000 POPULATION, 2008</b>		
Physicians	110	174
Primary care physicians	40	59
Dentists	47	69
<b>HOSPITALS, 2010</b>		
Community, acute care hospital beds per 100,000 population	146.4	178.43
Operating margin with net disproportionate share hospitals (Kaiser excluded)	3.3%	2.4%
Occupancy rate for licensed acute care beds (Kaiser included)	62.7%	57.8%
Average length of stay (in days) (Kaiser included)	4.3	4.5
Paid full-time equivalents per 1,000 adjusted patient days (Kaiser excluded)	16.3	15.8
Total operating expense per adjusted patient day (Kaiser excluded)	\$2,466	\$2,856

\*Foreclosure rates in 367 metropolitan statistical areas nationally ranged from 18.2% (Miami, FL) to 1% (College Station, TX).

Sources: US Census Bureau, 2010; California Health Interview Survey, 2009; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for California Counties and Metropolitan Statistical Areas, July 2011" (preliminary data not seasonally adjusted); California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; California Office of Statewide Health Planning and Development, Healthcare Information Division, Annual Financial Data, 2010; [www.foreclosureresponse.org](http://www.foreclosureresponse.org), 2011.

some residents isolated from health care services. These submarkets include:

- ▶ The more affluent cities in southern, and parts of eastern, Riverside County: Temecula, Murrieta, and Palm Springs
- ▶ The populated cities in southwestern San Bernardino County along the commuting corridor to Los Angeles: for example, Upland and Ontario
- ▶ The largely rural and poor High Desert region of northern San Bernardino County

Compared to the rest of the state, the Riverside/San Bernardino region has a higher proportion of Latino residents and a lower proportion of Asian residents. Education and income levels tend to be lower than state averages.

Over the last decade, the region experienced significant population growth: 30% between 2000 and 2010, compared to 10% for the state. Population growth in the early part of the decade was driven in part by people from nearby Los Angeles, Orange County, and San Diego moving eastward in search of more affordable housing. The population surge fueled a construction boom and housing market bubble that peaked in 2005–06. Population growth slowed to about 1% annually in 2011. Market observers noted that the weak economy reportedly drove some low-income immigrants out of the market in search of jobs elsewhere.

In part because of the large drop in construction jobs, the region's unemployment rate peaked at 15.1% in July 2010. By December 2011, the month of the site study, unemployment dropped to 12.2% but was still higher than the state average (10.9%) and almost double the area's unemployment rate when the recession started in December 2007 (6.3%). These high unemployment rates contributed to a loss of employer-sponsored health coverage and declining rates of private health insurance between 2007 and 2009, from 58.7% to 51.2%. In that period, more people became eligible for Medi-Cal coverage (from 18.5% to 21.2% of the

population) or went without insurance (the uninsured rate rose from 15.1% to 19.5%).

## Hospitals Retain Leverage over Health Plans

The hospital sector remains fragmented in Riverside/San Bernardino, with multiple hospitals and systems serving distinct geographic submarkets. The major hospital systems are concentrated near the population center in southwest San Bernardino County, which includes the cities of Fontana, San Bernardino, and Redlands, and the population center in northwest Riverside County, including the cities of Riverside and Moreno Valley.

The submarkets outside of the population centers tend to be served by smaller hospitals, including hospitals that are part of larger for-profit chains as well as nonprofit community hospitals. Many outlying areas lack inpatient capacity, while some populated areas are viewed as having too much capacity. There is relatively little hospital competition in rural areas, and more competition in the central, more populated areas and affluent submarkets. (See Hospital Systems in Riverside/San Bernardino on page 4.)

Since 2008, the recession has put the region's hospitals under increased financial pressure. With the decline in private health coverage during the recession, hospitals now rely more on Medicare and Medi-Cal, whose payment rates are below hospitals' average costs, according to hospital sources. Hospital executives also reported increased charity care and services to patients deemed medically indigent, including people seeking care in emergency departments (EDs). Overall, ED visits for non-Kaiser hospitals increased 8% across the market between 2008 and 2010 (during which time the population grew by only 3%), while inpatient volumes fell.

Even with these pressures, hospital margins have generally increased since 2008.<sup>2</sup> Hospitals' efforts to improve efficiency and contain costs — in some cases reducing staff through attrition and layoffs — have bolstered their bottom lines.

## Hospital Systems in Riverside/San Bernardino

This market is home to three main hospital systems, although none dominates.

Serving both counties, **Kaiser Permanente** holds the largest market share based on inpatient discharges (14% in 2010) and has grown slightly since 2008. Kaiser's market share for privately insured people is even higher since the system largely does not serve Medicaid and uninsured patients. Kaiser operates four hospitals, totaling more than 900 beds, in the cities of Fontana, Riverside, Moreno Valley, and Ontario.

**Loma Linda University Medical Center** is the second-largest hospital system, with 8.4% of discharges, and primarily serves San Bernardino County. The Loma Linda flagship campus includes Loma Linda University Medical Center and Children's Hospital, plus a new hospital in Murrieta in southwest Riverside County.

With the third-largest market share (7%), **Dignity Health** (formerly Catholic Healthcare West) owns two hospitals in San Bernardino: Saint Bernardine Medical Center and Community Hospital of San Bernardino. Geographically close to one another, Loma Linda and Dignity compete for routine cases and some complex specialized services.

In addition, each county operates a large public hospital — Riverside County Regional Medical Center (RCRMC) and, in San Bernardino County, Arrowhead Regional Medical Center (ARMC).

Both counties also are dotted with smaller nonprofit and for-profit systems and independent community hospitals, the largest of which include Eisenhower Medical Center and two district hospitals (managed by the for-profit Tenet Healthcare Corporation) in the Coachella Valley of East Riverside, Riverside Community Hospital owned by for-profit HCA Healthcare in central Riverside, and the San Antonio and Redlands Community hospitals in western and central San Bernardino County, respectively.

Recent payments from the Hospital Quality Assurance Fee Program have also helped hospitals' financial performance.<sup>3</sup>

Further, hospital executives reported higher payment rates from private insurers (although the increases were smaller than the double-digit increases before the recession). While hospitals have been financially challenged by the recession, they continue to have negotiating leverage with commercial health plans over payment methodology and rates. This is especially true given the region's widely dispersed population: Health plans must include many hospitals in their provider networks to ensure access to services.

Hospitals with strong market position and exclusive or high-demand specialty services have even more negotiating power. For example, with essentially a geographic monopoly in downtown Riverside, Riverside Community Hospital greatly increased its operating and total margins while also serving a safety-net role. Dignity Health has leverage in part because of the system's size — it includes more than 40 hospitals across three states. Loma Linda has a strong position as the only children's hospital in the region and the sole provider of several highly specialized services, including organ transplants.

Recent hospital expansion and construction in the region have been modest. New facilities are largely limited to the populated communities along the Interstate 10 corridor connecting San Bernardino to Los Angeles, and to areas lacking inpatient capacity, including the High Desert region in San Bernardino and Murrieta/Temecula in Riverside. To meet state seismic standards, hospitals are focusing more on retrofitting rather than replacing existing buildings, and the state's delay of seismic-standard compliance to 2020 is helping hospitals spread these costs over time. In addition, hospitals with better financial performance, such as Loma Linda, continue to invest in ambulatory care both to help gain referrals and to prepare for new payment methods under reform.

Another potential longer-term expansion of hospital capacity is the March LifeCare project, led by private

developer March LifeCare Development. This “medical city” would include a range of services, including ambulatory care, hospital care (including complex cardiovascular and cancer care), and skilled nursing, among others. Located on the site of the former March Air Force Base east of Riverside, demolition of the base’s buildings has been completed, but construction has not yet begun. March LifeCare has a private real estate investor on board and Riverside Medical Clinic as a partner, but lacks a hospital partner after Dignity pulled out because of financial constraints. At this point construction is on hold pending identification of investors.

### Growing Kaiser Presence

Kaiser is investing heavily and aggressively in the market. While Kaiser had been slower to grow here compared to elsewhere in the state, population growth and relatively light health plan and provider competition have increased the region’s attractiveness. Kaiser is rebuilding its flagship Fontana Medical Center to comply with seismic standards. It is expected to open in 2013 with less inpatient capacity but more specialized services, such as cardiovascular surgery, which will make Kaiser less reliant on contracting with other providers to care for its enrollees. This in-sourcing strategy will sever a longstanding Kaiser contract with Dignity for cardiovascular surgery, reportedly resulting in a loss of one-third of such cases for Dignity’s Saint Bernardine Medical Center. In 2011, Kaiser also added a fourth hospital with 224 beds in Ontario, also in San Bernardino County.

Through The Permanente Medical Group (TPMG), Kaiser is the largest employer of physicians in the market. In response to Kaiser’s growing enrollment, TPMG expanded from approximately 800 to almost 1,000 physicians in the market since 2008 — with specialists making up slightly more than half this number. Reportedly, new physicians are particularly interested in an employment model that provides more security and stability, and there are few other such options for physicians in the market beyond Kaiser. Kaiser requires a lower commitment to on-call coverage and

reportedly offers more generous retirement benefits than other physician organizations.

### Demand Outpacing Supply in an Otherwise Stable Physician Market

The Riverside/San Bernardino physician market faces particular challenges given its sprawling geography and weak economy. As of 2008 (the most recent data available), the per capita physician supply was the lowest in this market among the six study markets, and some observers reported that demand for physicians continues to outpace supply. In an attempt to grow physician supply over the long term, there has been an effort to expand the University of California, Riverside, medical school from a two-year program to a four-year program (students currently complete their last two years at UCLA). UC Riverside plans for the expanded medical school to focus less on research and more on primary care and community medicine, using existing hospitals and other facilities as teaching sites. Because of shortfalls in state and local budgets, however, UC Riverside has struggled to obtain sufficient funding for the expansion.

Providers reported difficulty in recruiting and retaining physicians, especially primary care physicians. Many respondents emphasized difficulties luring physicians from coastal areas, such as Los Angeles and Orange County, where many physicians prefer to live. Physician incomes are relatively low in Riverside/San Bernardino, stemming from historically lower payment rates from Medicare and commercial payers compared to nearby areas. Since 2008, the loss of patients with private coverage has also pressed physician incomes downward.

Though the market is still dominated by independent solo and small-group practices, these pressures have led some physicians to join larger independent practice associations (IPAs) or management services organizations (MSOs). Physicians entering the market tend to be attracted to employment in larger multispecialty groups that can offer a more turnkey practice environment and greater stability.

Reflecting this trend, Kaiser Permanente, the Loma Linda faculty practice, and other large physician groups such as Beaver Medical Group and Riverside Medical Clinic all have grown since 2008.

PrimeCare Medical Network/North American Medical Management (PrimeCare/NAMM), which serves both counties, and Riverside Physician Network in Riverside remain the largest IPAs. PrimeCare/NAMM is growing and, in some cases, acquiring the practices of interested physician members, mostly primary care practices. Also growing is EPIC Management, an MSO originally exclusive to Beaver Medical Group, which negotiates with HMOs on behalf of physicians as if they were part of Beaver Medical Group.

Physicians reportedly see several benefits to joining larger IPAs. As in other markets, IPAs offer administrative and care-management support to improve independent physicians' efficiency and ability to meet new reporting requirements and incentives from payers. For example, IPAs help practices adopt practice management information technology and electronic health records.

In addition, the virtual infrastructure offered by IPAs is well-suited to the geographically expansive and dispersed Riverside/San Bernardino market. Even as private health insurance has declined, large IPAs' geographic coverage and contracting expertise help physicians gain contracts and enhance negotiating ability with commercial and Medicare HMOs. Smaller IPAs, meanwhile, are reportedly struggling to maintain adequate financial reserves and contracts with insurers, leading some to merge or to join larger organizations.

## Hospitals Attempt to Align with Physicians

Historically, hospital-physician relationships in the market have been weak. Often, the more isolated hospitals are the only option in their submarkets and do not need to compete for physician referrals. Urban hospitals historically did not need to align tightly with physicians because high demand from privately insured patients helped drive business to them.

But the recession has prompted urban hospitals to ramp up efforts to align with physicians as the number of privately insured patients has dropped and hospital competition has increased. Also, physician alignment that enables exchange of information across providers and shared care-management strategies is a way for hospitals to assume greater clinical control across care settings in preparation for new risk-based payment arrangements under national health reform.

Although hospitals are skittish about a resurgence of capitated payment, working with other providers and assuming some financial risk for patient care likely will become necessary as ambulatory providers become more effective at managing care and keeping patients out of the hospital. Medical foundations — a model for hospitals to closely align with physicians that is seen in many other California markets — are not present in the region.<sup>4</sup>

Loma Linda and Dignity in particular have focused on different approaches to aligning with physicians. Loma Linda has a two-pronged strategy to enhance alignment. The first is to expand its faculty practice, which has grown from approximately 600 to 850 physicians since 2008, in part through its residency programs. Loma Linda's faculty practice groups are forming a single-practice corporation focused on improving physician productivity, collaborating on service lines and recruiting, and increasing clinical integration to prepare for reform.

Second, Loma Linda is seeking to affiliate with more community physicians. Loma Linda gained an equity stake in EPIC, Beaver Medical Group's MSO, and entered a joint venture with Redlands Community Hospital and Beaver Medical Group to build Highland Springs Medical Plaza, a satellite outpatient services and imaging campus in the Beaumont/Banning community in Riverside County. Loma Linda treats the high-acuity cases, while more routine cases are handled by lower-cost Redlands. In addition, Loma Linda is partnering with Tri-Valley Medical Group to establish ambulatory services in Murrieta, where Loma Linda has a new hospital.

Loma Linda is also adopting common health information technology across its hospitals and physicians — both in the faculty practice and in affiliated practices — to create infrastructure for new payment arrangements.

Likewise, Dignity Health is attempting to align with independent physicians in San Bernardino, partnering with PrimeCare/NAMM to create the Southern California Integrated Care Network (SCICN). SCICN will establish a network of physicians and apply PrimeCare/NAMM's experience with HMO contracting to help SCICN achieve formal clinical integration status, allowing the entity to accept risk for new patient populations, including those in preferred provider organizations (PPOs). Beyond San Bernardino, Dignity plans to partner with community hospitals to add physicians to its network in Riverside County.

### County Hospitals Remain Central to Safety Net

The safety nets for low-income people in Riverside and San Bernardino Counties continue to function separately but mirror each other in many ways, with few significant organizational changes since 2008. Both county governments remain active in health care, with ongoing efforts to address the region's significant and growing needs.

Located in the population centers, Riverside County Regional Medical Center (RCRMC) in Moreno Valley and Arrowhead Regional Medical Center (ARMC) in Colton (in San Bernardino County) are county-owned hospitals. Each has approximately 360 licensed acute care beds. The hospitals serve relatively few privately insured patients, who primarily present through their EDs and Level II trauma centers. ARMC operates the only burn center in the two counties. Both county hospitals rebuilt their campuses to meet seismic standards more than a decade ago, with ARMC in particular described by one respondent as now “having all the bells and whistles.”

Several community hospitals continue to play a smaller safety-net role, accepting some Medi-Cal patients but fewer

uninsured patients. These include Loma Linda, Dignity Health's Community Hospital of San Bernardino, Parkview Community Hospital in Riverside, John F. Kennedy Memorial Hospital (managed by Tenet) in Indio, and Palo Verde Hospital in Blythe.

Since 2008, the region's county hospitals have experienced a spike in demand from low-income people, primarily uninsured people rather than those covered by Medi-Cal. Although ARMC added 83 medical/surgical beds, ARMC and RCRMC both reported relatively stable inpatient volumes. In contrast, emergency department and outpatient/ambulatory volume increased significantly, especially at RCRMC, where outpatient visits increased by almost a third and ED visits by a quarter between 2008 and 2010. Responding to this increased demand, RCRMC slightly expanded its on-campus primary care capacity, and ARMC built a new medical office building and expanded existing services on its campus. Still, some respondents reported that volumes would have been higher if the outpatient facilities weren't already often at capacity.

Federal funding is increasingly important to the county hospitals as state and local revenue sources decline. While ARMC's financial status has improved since 2008, RCRMC's has worsened. Although these hospitals are owned and operated by their respective counties, they are not subsidized with general county revenues. While this has long been the case for ARMC, budget shortfalls over the last few years led Riverside County to eliminate support to RCRMC. Funding under the California Bridge to Reform Medi-Cal waiver has been critical for the county hospitals. As one hospital executive said, “It's federal money... bailing us out now... that's what's keeping us afloat.” In response to particular budget challenges since 2008, the hospitals launched an array of cost-cutting strategies. According to one respondent, ARMC has addressed all of the “low-hanging fruit” and is now turning to more complex changes in care delivery.

In addition to running their public hospitals, Riverside and San Bernardino County governments continue to serve

as the hubs of other safety-net functions. Both counties operate under the two-plan Medi-Cal managed care model, in which Molina Health Plan serves as the private plan and the Inland Empire Health Plan (IEHP) is the public plan operated by the two counties. IEHP is the dominant plan and covers approximately 500,000 people across the two counties, up about 40% since 2008 as more people gained Medi-Cal coverage. Also, with funding from state vehicle licensing fees and sales tax revenues, the county hospitals continue to operate medically indigent programs. Fairly comprehensive inpatient and outpatient services are available to low-income, uninsured people through county facilities and some private physicians and health centers, which are paid to care for enrollees.

However, the county governments have struggled since 2008 as more people met income eligibility criteria for the medically indigent programs while state funding remained flat. Enrollment in Riverside’s Medically Indigent Services Program “exploded,” according to one respondent, more than doubling over the last couple of years, while San Bernardino’s Medically Indigent Adult program grew more modestly. Riverside County allows undocumented immigrants to enroll, while San Bernardino does not.

In addition, the counties continue to offer primary care on their hospital campuses and in clinics throughout the community. ARMC operates three family health centers: two in the city of San Bernardino and one to the west in Fontana. San Bernardino County has transitioned four public health clinics into primary care clinics. In Riverside, RCRMC provides primary care on campus and recently acquired a mobile van to deliver school-based services. RCRMC also now operates a dozen family care centers that were formerly operated by the Riverside County Department of Public Health.

## Gradual Community Health Center Growth

The region has a handful of private community health centers and clinics that serve low-income people, with more capacity relative to population in Riverside County than in San Bernardino County. The private clinics include several FQHCs with multiple sites, a few single-site FQHCs and federal rural health centers, and several smaller clinics without federal status. FQHCs receive federal grants and cost-based Medi-Cal payments, among other benefits (see sidebar). Like other providers, private clinics tend to be clustered in the population centers, while the more sparsely populated areas, such as San Bernardino’s High Desert region and eastern Riverside County, remain underserved.

The largest FQHCs include Inland Behavioral and Health Services, with three facilities near the city of San Bernardino, and in Riverside, Clinicas de Salud del Pueblo, with two sites in the central part of the county (Coachella and Mecca) and a site in the far eastern part of the county (Blythe). Borrego Community Health Foundation, based

### FQHC and Look-Alike Designations

Community health centers that meet a host of federal requirements under Section 330 of the Public Health Service Act are deemed federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid and low-income, uninsured patients. FQHC designation provides benefits including federal grants to subsidize capital and operational costs, cost-based Medicaid payments, discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability coverage.

A smaller number of health centers have FQHC look-alike status, which provides most of the benefits that FQHCs receive but not federal grants. In managed care arrangements, FQHCs and look-alikes receive “wraparound” payments from the state to account for the difference between what the health plan or intermediary (such as an IPA) pays the health center and the cost-based rate to which the health center is entitled.



in San Diego, operates six facilities in western and central Riverside County. Community Health Systems serves both counties, with one site in San Bernardino and two sites in Riverside: one in the city of Riverside and one in Moreno Valley.

FQHC patient volume has increased since 2008, with some centers seeing approximately 40% more patient visits between 2008 and 2010, with further growth since. Others have had smaller increases or more stable volumes. The number of both Medi-Cal and uninsured patients grew, with FQHC respondents reporting their centers served new patients during the recession who hadn't previously used safety-net providers.

To treat more patients, FQHCs increasingly rely on funding from private foundations and the federal health center program. For example, Inland Behavioral and Health Services received a federal grant for a new site in Banning, and an FQHC in Adelanto received a federal grant to remodel and expand school-based facilities. In contrast, state support has declined. For example, the Early Access to Primary Care funds to subsidize care for uninsured patients were eliminated, as were some optional benefits under Medi-Cal, including dental care for adults.

But while FQHC patient volume in Riverside/San Bernardino has increased, market observers reported that health centers in the region have been slower to receive federal status and grants than health centers in many other parts of California. State data indicate that the region has fewer than half the FQHCs per capita than the state average, even with the area's population more likely to be low income and uninsured or covered by Medi-Cal. One FQHC built a new site and expected to receive a federal grant to support it. When the grant was denied, the health center was able to obtain some funding from private foundations, providers, and health plans, but still had to borrow money to maintain operations.

Market observers offered several reasons for the slow FQHC development in the region. One contributing factor is the large safety-net role of county hospitals and clinics, which absorb available county funds and leave less support for developing private clinics. With increasingly strained county budgets since 2008, there is little local funding and other support to help health centers demonstrate need and to build the infrastructure and competencies needed to gain federal status and secure ongoing grants.

Another possible factor in lagging FQHC development is that until recently, Riverside and San Bernardino Counties lacked health center coalitions to help develop and support health centers. However, there has been activity on this front in recent years, with the Community Clinic Association of San Bernardino County being created in 2010 with startup funding from Kaiser Permanente. In addition, the San Diego Council of Community Clinics expanded to serve Riverside County, with Clinicas de Salud del Pueblo now a member.

As a couple of FQHC organizations have crossed county lines, respondents noted both appreciation for the assistance but also some unease about "stepping on each other's territory." Even as they ramp up efforts to secure federal grants, health centers reportedly are guarded about sharing their expansion plans and have collaborated little with each other, especially as federal budget shortfalls reduced funding initially available for expansions under national health reform.

Still, there are other signs of growing safety-net collaboration. In both counties, health centers and county and private hospitals are working together in various ways to improve access to specialty care for low-income patients. For example, Kaiser, Loma Linda, ARMC, and others sponsored a countywide conference with community clinics to explore strategies for improving the primary care workforce and specialty care access.

## Preparing for Reform

In preparing for national health reform, hospitals and physician organizations alike are emphasizing ambulatory and physician services over more costly inpatient care. As more people gain coverage, market observers expect tight inpatient hospital capacity in some parts of the region, while inpatient capacity in the more populated areas might be sufficient. Providers are working to improve care management and develop new payment arrangements that de-emphasize inpatient services. For instance, physician organizations with more sophisticated care-management capabilities, such as the Beaver/EPIC MSO and PrimeCare/NAMM, are moving to global risk payment arrangements that allow them to share savings with their hospital partners. PrimeCare/NAMM and Heritage California (an affiliate of Heritage Provider Network, which extends beyond the Riverside market) were selected as Medicare Pioneer Accountable Care Organizations (ACOs).<sup>5</sup>

Respondents are concerned that physician shortages — particularly for primary care — will worsen as more people gain coverage and more emphasis is placed on ambulatory care. Many respondents are hopeful that the UC Riverside expansion will come to fruition. Indeed, a recent media report indicates the medical school has secured commitments of \$100 million over 10 years, largely from the University of California, local government, and community health organizations, to move toward gaining accreditation for the expanded program.

In preparation for the 2014 Medicaid expansion, both counties in January 2012 started transitioning their medically indigent populations to new Low Income Health Programs (LIHPs) under the state's Bridge to Reform Medi-Cal waiver.<sup>6</sup> LIHPs are designed to create a more formal primary care medical home and managed care environment for enrollees. Riverside's program is Riverside County Healthcare and San Bernardino's is Arrowcare; both expect to enroll approximately 20,000 people, similar to the size of the current medically indigent programs but still a fraction of the

number eligible. Given the expected costs, income eligibility in both counties will not quite reach 133% of the federal poverty level (\$14,856 for an individual in 2012) to match Medi-Cal eligibility. To facilitate eventual transition to Medi-Cal coverage, Arrowcare enrollment activities have shifted from the county hospital to Medi-Cal workers.

To meet state network requirements and to serve enrollees, both counties are attempting to create broader provider networks from the set of providers they have used for the medically indigent programs. They are including more community clinics and have approximately doubled the number of primary care sites. Still, implementation delays and payment issues have frustrated some providers. At least one FQHC chose not to participate based on the expectation that its costs of providing the required services would significantly exceed payment.

While safety-net providers expect growth in Medi-Cal patients under reform — both from the providers' existing uninsured patients obtaining coverage and from newly insured patients who may not have used safety-net providers before — they also expect increased competition for these patients. Indeed, some private hospitals are positioning themselves to care for more Medi-Cal patients: Loma Linda University applied for FQHC status for its primary care clinic, and Dignity is working with PrimeCare/NAMM to take on the Medi-Cal Seniors and Persons with Disabilities (referred to as Aged, Blind, and Disabled in other states) population as the state moves that group into managed care.

In response, safety-net providers are trying to become "providers of choice." The county hospitals are working to better demonstrate their high-quality outcomes and improve the patient experience by, for example, offering better availability of primary and specialty care appointments.

Finally, the new Delivery System Reform Incentive Payments that the county hospitals receive under the Medi-Cal waiver are tied to their progress in establishing medical homes and improving care coordination. Since the county hospitals already offer extensive primary care in the

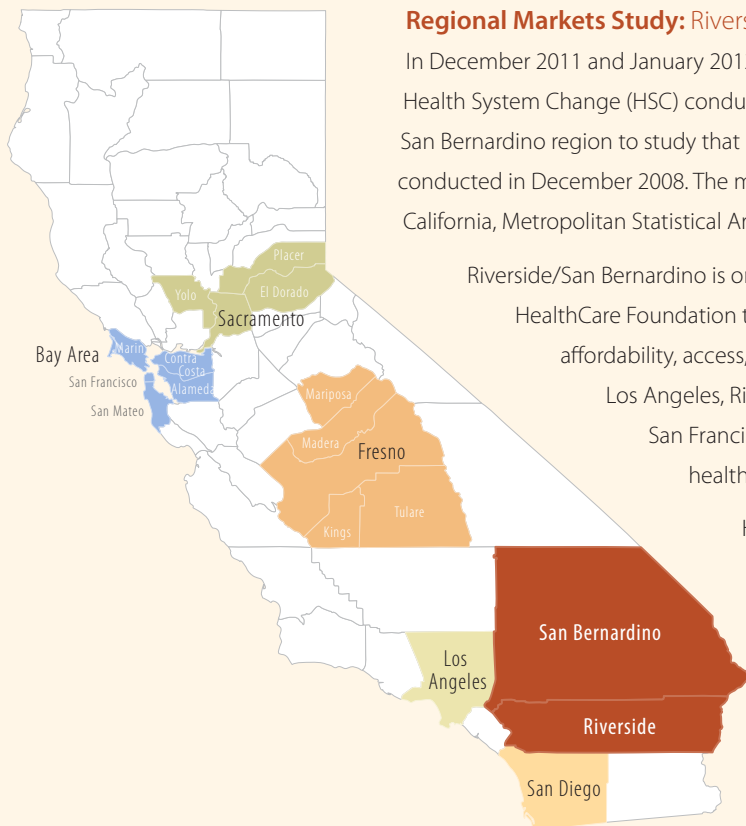
community and are aligned with their physicians — primary care physicians largely are employed through the county, and specialists are contracted through exclusive groups — market observers considered them well on their way to developing integrated delivery systems that could eventually participate in innovative payment arrangements.

## Issues to Track

- ▶ Will health provider capacity be sufficient throughout the Riverside/San Bernardino region as more people are covered under health reform?
- ▶ To what extent will physicians align more with each other and with hospitals to gain more privately insured patients and to prepare for new payment arrangements? How effective will they be in competing with Kaiser?
- ▶ What will be the net impact on hospitals as more people gain coverage under reform but subsidies end or decline (the hospital fee program, plus Medi-Cal waiver funds for public hospitals)?
- ▶ Will community health center and FQHC development pick up in this market or continue to lag? What will the impact be on access to care? Will new health center associations encourage greater collaboration in this market?
- ▶ Will the market be able to recruit or develop enough primary care providers to handle increased demand for care under reform?

## ENDNOTES

1. Medina, Jennifer, “In California, Economic Gap of East vs. West,” *The New York Times* (April 4, 2012).
2. California Office of Statewide Planning and Development, Healthcare Information Division, Annual Financial Data, 2010. Data reflect each hospital system’s fiscal year.
3. Passed by the California legislature in 2009, the Hospital Quality Assurance Fee Program (commonly known as the hospital fee program) generates additional funding for hospitals serving relatively large numbers of Medi-Cal patients. Hospitals pay a fee based on their overall volume of inpatient days; after the addition of federal matching dollars, the funds are redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. Approximately 20% of hospitals are net contributors to the program. Originally, the program covered only the period from April 2009 through December 2010, but it has been renewed twice (through 2013). Payments were first made to hospitals at the end of 2010.
4. Because California’s corporate practice of medicine law prohibits hospitals from directly employing physicians, some hospitals sponsor medical foundations as a way to align with physicians. Under the medical foundation model, physicians either contract with the foundation through an affiliated IPA or are part of a medical group that contracts exclusively with the foundation through a professional services arrangement.
5. The Centers for Medicare and Medicaid Services (CMS) Innovation Center created the Medicare Pioneer ACO model for health care providers already working to coordinate services across care settings to achieve greater care coordination and cost savings with a traditional Medicare (fee-for-service) beneficiary population. Participating organizations share in both savings and losses for a defined population, and have the opportunity to move to a prospective capitated payment method in year three. There are 32 ACOs participating in this model nationwide for the period 2012–15.
6. LIHP does not technically provide health insurance but requires counties to provide a benefit similar to Medi-Cal, which is typically more comprehensive than traditional medically indigent programs. Counties receive federal matching funds to help support the cost of the LIHP. Still, a change in federal Ryan White policy — which requires the LIHP to be the primary payer of services to HIV/AIDS patients for whom Ryan White was previously the primary payer — has driven up expected costs of the programs.



### Regional Markets Study: Riverside/San Bernardino

In December 2011 and January 2012, a team of researchers from the Center for Studying Health System Change (HSC) conducted interviews with health care leaders in the Riverside/San Bernardino region to study that market's local health care system and update a similar study conducted in December 2008. The market encompasses the Riverside-San Bernardino-Ontario, California, Metropolitan Statistical Area, which includes Riverside and San Bernardino Counties.

Riverside/San Bernardino is one of six markets being studied on behalf of the California HealthCare Foundation to gain insights into regional characteristics in health care affordability, access, and quality. The six markets included in the project — Fresno, Los Angeles, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area — reflect a range of economic, demographic, health care delivery, and financing conditions in California.

HSC researchers interviewed 23 respondents specific to this market, including executives from hospitals, physician organizations, community clinics, and programs for low-income people. Interviews with 18 health plan executives and other respondents at the state level also informed this report.

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