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Riverside/San Bernardino:
Despite Large Medi-Cal Expansion, Many Uninsured Remain

Summary of Findings

Since the last round of this study in 2011-2012, the Inland Empire of Riverside and San Bernardino Counties has continued to recover from the 2008 recession. However, the income level for this region's population remains relatively low, and employment growth is characterized by lower-wage jobs with fewer health insurance benefits. This backdrop has affected the strategies and relationships among the region's health care providers, who are in relatively short supply and are segmented in the main urban area and other submarkets across this vast region.

Key developments include:

- **Many remain uninsured, even after large Medi-Cal expansion.** The prevalence of low incomes across the Inland Empire contributed to an approximately 50% increase in Medi-Cal enrollees in this region since the state expanded the program in 2014. However, because of a concurrent erosion of commercial coverage over the last few years and difficulties reaching people in more remote parts of this vast region, a relatively high proportion of Inland Empire residents still lacked coverage by the end of 2014, although Medi-Cal enrollment continued to climb throughout 2015. Moreover, despite some improvements, the community lacks a robust, extensive safety net to adequately serve low-income people's primary care, specialty care, and behavioral health needs throughout the whole region.
- **Provider capacity grew modestly.** The market continues to grapple with a short supply of hospital beds and physicians, particularly primary care physicians (PCPs) and psychiatrists. Kaiser Permanente, Loma Linda University Medical Center, and Dignity Health remain the largest hospital systems. Over the last few years, some hospitals have expanded their geographic reach in more affluent markets, while many other areas remain underserved. Many hospitals lack the financial resources to build new capacity and address state seismic requirements. Faced with ongoing challenges competing with more desirable coastal communities, many providers are focusing on training new physicians, particularly through the new medical school at the University of California, Riverside.
- **Kaiser Permanente poses an increasing competitive threat.** Kaiser Permanente's presence in the market continues to expand, leaving other hospitals and physician organizations struggling to compete for the remaining commercial patients. With its integrated delivery system and health plan that takes full financial risk, Kaiser has more control over system improvement initiatives and patient experience; its clinical efficiencies allow for competitive premium pricing, and its rich benefit structure enables Kaiser to offer physicians attractive employment opportunities.
- **Pressures on independent physician practices mount.** While many physicians remain in independent or small

practices, an eroding payer mix and other growing financial and administrative pressures are driving physicians either to seek help in remaining independent, or to trade independence for more stability. Established physician practices are contracting with large independent practice associations (IPAs) and management services organizations (MSOs) for greater levels of administrative and clinical support, while newly minted physicians are more likely to seek employment with Kaiser's medical group or other large medical groups in the market.

- **Large independent provider organizations lead the market in taking financial risk.** The larger IPAs and MSOs in this market — including PrimeCare Medical Network, Heritage Provider Network, and EPIC Management — have sufficient size and have developed the experience, resources, and technology to manage total patient care. Over the last three years, they have expanded the number of commercial and Medicare patients they manage under full-risk contracts.

- **Slow and cautious steps are underway toward developing integrated care networks.** Some hospitals in this market are making organizational changes and establishing the building blocks of integrated delivery systems to help them both in their current fee-for-service environment as well as to prepare for value-based payments. However, these arrangements are nascent and less-developed than in other California markets. In a key example, the medical foundation model as a strategy to affiliate more closely with physicians (especially primary care physicians)

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

	Riverside/San Bernardino	California
POPULATION STATISTICS, 2014		
Total population	4,441,890	38,802,500
Population growth, 10-year	18.6%	9.1%
Population growth, 5-year	7.2%	5.0%
AGE OF POPULATION, 2014		
Under 5 years old	7.3%	6.6%
Under 18 years old	26.9%	24.1%
18 to 64 years old	61.9%	63.1%
65 years and older	11.1%	12.9%
RACE/ETHNICITY, 2014		
Asian non-Latino	5.3%	13.3%
Black non-Latino	6.8%	5.5%
Latino	48.6%	38.9%
White non-Latino	35.5%	38.8%
Other race non-Latino	3.8%	3.5%
Foreign-born	22.3%	28.5%
EDUCATION, 2014		
High school diploma or higher, adults 25 and older	82.3%	83.4%
College degree or higher, adults 25 and older	22.2%	37.9%
HEALTH STATUS, 2014		
Fair/poor health	16.1%	17.1%
Diabetes	8.8%	8.9%
Asthma	16.1%	14.0%
Heart disease, adults	4.5%	6.1%
ECONOMIC INDICATORS, 2014		
Below 100% federal poverty level	22.5%	18.4%
Below 200% federal poverty level	46.3%	40.7%
Household income above $100,000	18.6%	22.9%
Unemployment rate	8.2%	7.5%
HEALTH INSURANCE, ALL AGES, 2014		
Private insurance	42.0%	51.2%
Medicare	9.9%	10.4%
Medi-Cal and other public programs	30.9%	26.5%
Uninsured	17.2%	11.9%
PHYSICIANS PER 100,000 POPULATION, 2011		
Physicians	120	194
Primary care physicians	43	64
Specialists	77	130
HOSPITALS, 2014		
Community, acute care hospital beds per 100,000 population†	148.3	181.8
Operating margin, acute care hospitals*	0.1%	3.8%
Occupancy rate for licensed acute care beds†	55.2%	53.0%
Average length of stay, in days†	4.2	4.4
Paid full-time equivalents per 1,000 adjusted patient days*	16.2	16.6
Total operating expense per adjusted patient day*	$2,819	$3,417

*Kaiser excluded.
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Sources: US Census Bureau, 2014; California Health Interview Survey, 2014; "Monthly Labor Force Data for California Counties and Metropolitan Statistical Areas, 2014" (data not seasonally adjusted), State of California Employment Development Department; "California Physicians: Supply or Scarcity?" California Health Care Foundation, March 2014; Annual Financial Data, California Office of Statewide Health Planning and Development, 2014.

is new to this market. Also, Loma Linda and Riverside University Health System (RUHS, the hospital and health services operated by Riverside County) reportedly are exploring formation of a clinically integrated network, but the structure is new and will need significant development.

- **Distinction between mainstream and safety-net providers is blurry.** While the Medi-Cal expansion has created more demand for care and stressed the already short supply of providers, its impact on access to care is complex. The erosion of commercial coverage plus Medi-Cal health plan incentives to boost participation has led some primarily commercial and Medicare providers to be more willing to serve Medi-Cal enrollees, leading to improved access for some people. Also, community clinics have received more federal dollars, allowing them to expand modestly. While these changes have taken some pressure off the two county hospitals — Riverside University Health System Medical Center (RUHSMC) and Arrowhead Regional Medical Center (ARMC) — these facilities are bracing for a decline in subsidies and strategizing ways to generate more revenue.

Market Overview

The Inland Empire of Riverside and San Bernardino Counties (see map on page 16) is home to almost 4.4 million people and covers an immense geographic region of over 27,000 square miles, an area nearly as large as the state of South Carolina. Population growth has slowed, but at 7% over the last five years it continues to exceed that of other regions in this study and California as a whole (see Table 1). Over the three years since the previous round of the study was conducted, the urban centers in the western end of the region continue to attract many commuters, retirees, and others from Los Angeles, Orange County, and San Diego who seek affordable housing. The rest of the region is largely divided by mountain ranges, deserts, and protected land, creating smaller local submarkets that function rather independently.

The Inland Empire's economy has gradually improved since the 2008 recession, yet remains socioeconomically disadvantaged compared to the state average and most of the other study markets. The unemployment rate improved significantly over the last three years but remains slightly higher than the state average. Low educational attainment and incomes persist. Further, the middle class shrank as the proportion of people living below 200% of the federal poverty level (FPL) grew slightly and the proportion of people earning above $100,000 annually increased.

Related to the region's low wage levels, the market continues to have smaller rates of private insurance coverage and higher rates of Medi-Cal coverage than California overall and most of the other study markets (except Fresno). Despite the addition of subsidized and other commercial coverage through Covered California (the state's new insurance marketplace under the Affordable Care Act [ACA]), many post-recession employment opportunities offer lower wages and benefits than before, which has contributed to further erosion in employer-sponsored coverage. Through the state's 2014 expansion of eligibility to adults earning under 138% FPL, as allowed by the ACA, almost a third of the population was enrolled in Medi-Cal that year.

Previously, the Inland Empire's portion of residents lacking health insurance was relatively average compared to the other study regions and the state. While these other areas saw their uninsurance rate decline over the last three years as Medi-Cal enrollment grew, the Inland Empire's erosion of commercial coverage resulted in an uptick in the uninsurance rate, to 17% in 2014. This rate far exceeds that of the other study markets and the state average of 12%. However, many people have since gained Medi-Cal (approximately 93,000 between January and October 2015, an increase of approximately 6%), which has likely brought the uninsurance rate down.

The Inland Empire's long-standing shortage of health care providers persists. The market has fewer licensed hospital beds and physicians relative to the population than the state average; physician supply is the lowest among the regions studied.

While many California markets face physician shortages, the Inland Empire faces a particular disadvantage recruiting physicians as it competes with nearby Los Angeles, San Diego, and Orange Counties, which are home to coastal communities populated with more affluent, well-insured residents.

Also, certain parts of the Inland Empire are more attractive to health care providers than others. In addition to population centers of the cities of Riverside, San Bernardino, Ontario, and Chino, providers are increasingly drawn to the relatively affluent, high-growth areas in the far western suburbs of San Bernardino County (including Chino Hills and Rancho Cucamonga), as well as southern and eastern Riverside County (including Temecula, Murrieta, Coachella Valley, and Palm Springs). In contrast, the largely rural and poor areas (such as High Desert, Victorville, and Apple Valley in northern San Bernardino County, and eastern Coachella Valley in Riverside County) remain particularly underserved.

Medi-Cal Enrollment Growth Pervades Market but Many Uninsured Remain

By October 2015, Medi-Cal enrollment in the Inland Empire ballooned to almost 1.7 million people, a 57% increase since the beginning of the state's Medi-Cal expansion in January 2014. This growth surpassed many market observers' expectations, who attributed the spike in part to slow recovery from the recession and persistent low incomes, as well as early county preparations. Facilitated by the state's "Bridge to Reform" Medicaid waiver, both counties implemented Low Income Health Programs (LIHPs) by 2012, which transitioned low-income people to Medi-Cal-like programs. Enrolling double the number of people originally expected, these programs linked approximately 35,000 people in Riverside and 40,000 people in San Bernardino to primary care providers. Approximately 55,000 LIHP enrollees transitioned to Medi-Cal coverage in 2014. Additional outreach activities by safety-net providers and other community organizations further boosted Medi-Cal enrollment, particularly among people newly eligible for the program.

The vast majority of Medi-Cal enrollees are served under the Two-Plan Model of managed care. In this model, enrollees can choose between a county-operated plan (known as a "local initiative") and a private health plan. The Inland Empire Health Plan (IEHP), which was jointly created by both counties, remains the local initiative. With approximately 1.1 million members by January 2016, IEHP grew more than 40% since the end of 2013 and holds almost 90% of the market's total enrollment, representing an increase in market share. IEHP's strong market presence is related, in part, to its performance on a composite measure of quality and member satisfaction.[1] Molina Healthcare remains the private plan option; its enrollment increased almost 40% to about 170,000 members during the same period.

Market observers note that more uninsured people are gaining coverage, but also that the Inland Empire faces particular challenges in whittling down its uninsurance rate. Conducting outreach throughout the large, remote areas of the region is challenging, and there are many people who earn too much to qualify for Medi-Cal but for whom even subsidized Covered California products may be unaffordable. Pending available funding, new state legislation — the Health for All Kids Act — is expected to extend coverage to some of the undocumented children in this market in 2016.

Both counties retain medically indigent programs to help low-income uninsured people access care. At up to 200% FPL, income eligibility for the programs is higher than that of Medi-Cal, yet enrollment is limited to people who are acutely ill, as assessed by the counties. Enrollees receive care through the county hospitals and their clinics. However, much of the realignment funds that each county receives from the state to support these programs have been redirected.[2] Riverside disregards immigration status and now serves approximately 7,000 people, while San Bernardino does not extend enrollment to undocumented immigrants and reportedly has only about 500 enrollees.[3] As a result, many people likely go without routine and ongoing care.

Providers in Segmented Market Attempt to Grow

In part because of its vast landscape, the Inland Empire continues to host multiple hospital systems and physician organizations and is not dominated by any one provider system. Instead, the provider market remains segmented, composed of the many providers in the urban centers, as well as separate, concentrated provider markets in the smaller population centers dotting the outlying areas. This composition and limited capacity has historically tempered provider competition and tends to make for less contentious provider-health plan relationships because health plans need these hospitals in their networks. Hospitals have continued to use traditional strategies to generate revenues, such as by focusing on lucrative service lines such as cardiology, neurology, and oncology. More recently, however, providers have made efforts to expand in targeted ways both to address capacity constraints and to respond to Kaiser Permanente's growing advantages in the market.

Hospital Market Remains Segmented and Unconsolidated

Inland Empire residents continue to receive care from more than 30 hospitals throughout the region. Representing a mix of systems and independent facilities, these hospitals consist of an academic medical center as well as nonprofit community, for-profit, county-owned, and district hospitals.

Five large hospitals and systems in the core urban area of southwest San Bernardino County and northwest Riverside County continue to serve their immediate neighborhoods for a variety of services, and provide specialized services for the broader market. Demonstrating the unconsolidated nature of the hospital market, these hospitals together still provide just over 40% of total patient discharges in the region, although market share shifted mildly among them between 2011 and 2014.[4]

- Kaiser Permanente operates four hospitals (two in Riverside and two in San Bernardino) and holds the largest market share, providing a stable 13% of discharges.
- Loma Linda University Medical Center, an academic medical center affiliated with Loma Linda University, operates its flagship facility and children's hospital in San Bernardino, plus a smaller hospital in Riverside. It also operates a heart and surgical hospital in Redlands. As the region's only children's hospital and its main quaternary hospital, Loma Linda is a "must have" in commercial insurers' networks and provides large volumes of high-end specialty care, which are relatively well-reimbursed. It is the sole Level I trauma center in the Inland Empire and a large Medi-Cal provider. Between 2011 and 2014, Loma Linda's market share increased from 9% to 12%.
- Dignity Health's two hospitals in San Bernardino — St. Bernardine Medical Center, which offers a full range of services but focuses on cardiovascular care, and Community Hospital of San Bernardino, which offers more limited services — provide 7% of discharges, down from 8% in 2011.
- The two county hospitals — Riverside University Health System Medical Center (previously Riverside County Regional Medical Center) and San Bernardino County's Arrowhead Regional Medical Center (ARMC) — each provide a relatively stable 5% of discharges. In addition to being the core safety-net hospitals for low-income people, both county hospitals offer Level II trauma services, and ARMC operates the Inland Empire's sole burn center, for the broader community.

A number of community hospitals provide routine hospital care for their immediate areas, yet play a more prominent role than similar hospitals in other markets. In the more urban areas these include Riverside Community Hospital (owned by the for-profit HCA Healthcare system), which has a sizable 7% market share, while independent San Antonio Regional Hospital and Redlands Community Hospital in San Bernardino County have a smaller presence.

Several private hospitals continue to serve the outlying submarkets, with each serving a primary role in its local community but holding low market share for the total region. Eisenhower Medical Center and Tenet Healthcare (with three hospitals) both serve eastern Riverside County. Universal-Southwest's four hospitals serve southwest Riverside County and the city of Corona. St. Joseph Health, a Catholic hospital system that recently merged with Providence Health, operates St. Mary Medical Center in Apple Valley. Also, the broader northern San Bernardino area (Apple Valley, High Desert, and Victorville) is served by two for-profit systems: Prime Health Care's Desert Valley Hospital and KPC Global's Victor Valley Global Medical Center.

Hospitals Shift Beds

The larger hospital systems have expanded their geographic reach over the last three years, building new facilities to shift beds to growing, more affluent markets. Loma Linda built a new facility in Murrieta, and Kaiser built a hospital in Ontario (it also rebuilt but downsized its Fontana hospital, for a net increase of about 100 beds) and will begin a new hospital and medical office complex in Murrieta.[5] Also, Universal Health Services built its Temecula Valley Hospital. In 2016, San Antonio Regional Hospital is adding an inpatient tower.

However, the number of acute care hospital beds has not significantly changed relative to the size of the population. While this is consistent with trends in other markets to focus on outpatient services over inpatient use, many hospitals in the Inland Empire lack sufficient resources to finance targeted renovations and expansions. Hospital margins historically have been low in this market, and currently hospitals are not breaking even overall: the average operating margin was –0.5% in 2014, down from 1.4% in 2011. The main financial pressures for these hospitals include their payer mix as well as a growing presence of narrow-network commercial products, from which they could be excluded if they don't meet cost and quality thresholds. Pressure also comes from high-deductible products that generate more administrative burden for hospitals and more bad debt when patients cannot afford their out-of-pocket payments.

As a result, the particularly underbedded outlying areas of the market are still struggling to gain needed hospital beds. For example, a major renovation and expansion project at San Gorgonio Memorial Hospital stalled due to a lack of capital. With the overall scope for the hospital still under development, St. Mary Medical Center is planning a new campus in the High Desert, which will bring the first trauma center to the area.[6] Psychiatric beds reportedly remain in short supply across the market.

Further, the need to meet future state seismic standards continues to be a significant financial pressure for area hospitals. Many hospitals lack the capital and plans necessary to reach compliance by the current 2030 deadline. Overall, the larger hospitals in the market (especially Kaiser and the two county hospitals) are better prepared than the smaller ones. Loma Linda recently began several replacement facilities, including a new adult inpatient facility and an expanded children's hospital on its main campus.[7] However, the Dignity system and many of the smaller hospitals reportedly are not prepared to make needed changes; some are waiting a few years, perhaps to see if the state further extends the deadline. Some hospitals reportedly are considering affiliations and potentially even mergers to gain access to needed capital, although the amount needed to make some facilities compliant will likely deter buyers.

Kaiser Permanente's Influence Spreads

Kaiser Permanente's role in the Inland Empire health care market has expanded over the last three years. Its health plan holds a sizable and growing share — about a quarter currently — of the total commercially insured population. With the growth in health plan members, Kaiser has started providing services that it previously contracted with other hospitals to provide. Most recently, Kaiser in-sourced cardiac surgery and ended its contract with Dignity, reportedly with negative financial impacts for Dignity. Kaiser continues to send

bariatric surgery cases to Dignity and highly specialized pediatric (e.g., cardiology, oncology) and quaternary cases to Loma Linda and academic medical centers outside the market.

Yet Kaiser's share of the hospital market has stayed relatively stable over the last three years because of its system-wide initiative to reduce its members' inpatient use. With combined roles as an integrated delivery system model with a health plan that takes full financial risk, Kaiser faces different incentives than hospitals that receive more revenue by providing more inpatient care under the fee-for-service payment system. Kaiser instead focuses on treating members on an ambulatory basis and is a market leader in population health, providing many medical and non-medical support services. Kaiser has become a major competitor to other hospitals and physician organizations in the market, driving them to find ways to better integrate services and improve care delivery.

Independent Practice Model Persists, While Younger Physicians Join Larger Groups

While many physicians remain in independent or small practices, the eroding payer mix and other growing financial and administrative pressures are driving physicians to one of two divergent paths: to obtain more practice support, allowing them to remain independent, or to join larger multi-specialty medical groups, which offer less autonomy but more resources and stability.

For physicians wanting to follow the first track and remain independent, independent practice associations (IPAs) or management services organizations (MSOs) offer several benefits: they provide a contracting vehicle with insurers, they allow practices to outsource time and resource-intensive administrative tasks, and they provide clinical support. Three such entities play a large and increasing role in supporting private practice physicians in the Inland Empire. PrimeCare Medical Network IPA is composed of a stable set of 14 smaller IPAs with over 350 contracted PCPs and 1,000 specialists. Based in Los Angeles, Heritage Provider Network also has a presence in other Southern California markets (and New York and Arizona) including the Inland Empire, particularly in the High Desert, Coachella Valley, and Temecula. EPIC Management is the largest locally operated MSO in the market (owned by Beaver Medical Group; see below), which serves approximately 500 physicians in the market (at Beaver, other small medical groups, and IPAs).

To remain viable and competitive, these organizations have diversified the types of practice arrangements they offer physicians. For example, Heritage started as a medical group model and over time added the IPA option, which now exceeds its medical group presence. In the Inland Empire, Heritage retains a large medical group presence in the Coachella Valley and Victorville.

Some physicians — younger, newer physicians in particular — are eschewing independent practice in favor of joining several large medical group options in the region. These medical groups offer a turnkey practice option, where physicians gain access to infrastructure and resources that ease physician administrative burdens and offer better work-life balance. Medical groups help cover the costs of purchasing and implementing electronic health records and other expensive information technology infrastructure needed to, for example, coordinate care and monitor and report quality-of-care measures.

The largest independent medical group options in the Inland Empire include the Beaver Medical Group (with approximately 200 physicians) and Riverside Medical Clinic (with approximately 135 physicians). The breadth and depth of physicians in these groups make them attractive potential partners for hospitals (see Value-Based Payment section below). These groups have grown modestly over the last three years by recruiting newly trained physicians and, to a lesser extent, bringing in established physicians from outside the Inland Empire. In some cases, medical groups have offered higher compensation rates and/or an ownership stake in their practice and other practice-owned subsidiaries in order to attract enough new doctors to support their growth. Still, they face significant competition from Kaiser, especially for PCPs.

Indeed, many new physicians who want to avoid the administrative and financial aspects of medical practice and solely focus on treating patients are drawn to the employment model available through Kaiser's physician arm, the Southern California Permanente Medical Group (SCPMG). SCPMG is the largest medical group in the market and has grown faster than the other large groups, to approximately 950 physicians currently. The attractiveness of Kaiser's integrated care model, along with its competitive compensation and working conditions, present a direct challenge for other providers trying to hire physicians; one market observer described Kaiser as a "physician vacuum."

While the medical foundation model is common in many California markets, Inland Empire hospitals historically have not used this model to align with physicians.[8] This is due in part to difficulty obtaining the substantial capital needed to fund foundations. Also, the relatively low supply of beds in the market has meant that hospitals have not had to actively seek patient referrals from physicians to the same degree as hospitals in overbedded markets.

Loma Linda maintains a large network of physicians in its affiliated faculty practice: The Faculty Physicians and Surgeons of Loma Linda School of Medicine, which offers physicians administrative resources, plus teaching and research opportunities. This group has grown modestly in recent years, to 800 physicians. Historically made up of mostly specialists, PCPs comprise most of its newer physicians, signaling a shift in Loma Linda's strategic plans as it strives to develop more of a primary care base to generate more referrals and to potentially form the base of an integrated care network in the future (see Value-Based Payment section below). In addition, the new medical school at the University of California, Riverside (UCR) provides another faculty practice option for physicians (see below).

Cultivating More Physicians

Given the difficulty competing with other markets for physicians, the Inland Empire has increasingly focused on "growing its own" physicians by creating more education and training opportunities. Market observers note that once individuals establish a personal life, they are much more likely to stay in the community long-term. Several efforts reportedly are starting to help, but respondents still consider these inadequate to date.

The biggest effort to train more physicians in the last three years is the opening of the medical school at UCR in 2013. The school is offering scholarships to recruit medical students willing to stay and practice primary care in the Inland Empire for at least five years after their residency.[9] The school is actively growing its clinical faculty and clinical partnerships to create and support residencies throughout the market, with a particular focus on the areas of greatest need: family medicine and psychiatry. UCR also supplements Loma Linda's residency programs and supports other providers' efforts to expand their residency programs. For example, Riverside Community Hospital recently received accreditation to start an internal medicine residency training program in coordination with UCR in 2016.

In addition, many other hospitals and large physician organizations are starting or expanding their residency programs to cultivate their own physicians and, for some, to market themselves as teaching institutions. These include Kaiser, Riverside Medical Clinic, Eisenhower Medical Center, Desert Regional Medical Center, and Hemet Valley Medical Center. Many capture UCR graduates as well as students from outside of the area (see also Safety Net section below).

Steps Toward Value-Based Payment

As noted, the Inland Empire provider market remains quite traditional overall, with many providers functioning rather independently and fee-for-service payments that promote volume over value remaining common (particularly among specialists and hospitals). However, most physician

organizations have long assumed professional risk in their contracts with HMOs, which provides a managed care foundation that physician organizations can build upon to accept greater financial risk.

Some of the largest independent physician organizations have taken steps to assume greater financial risk for at least a subset of the commercially insured and Medicare Advantage patients they serve. These organizations have the size, resources, and technology to engage in population health and patient care management under risk-based payment mechanisms. Heritage is particularly advanced and takes full risk for all of its Medicare Advantage and commercial HMO patients, and recently entered a full-risk arrangement for Medi-Cal patients.[10] EPIC Management has partnered with Redlands Community Hospital and Loma Linda to take on full-risk contracting for more than 70,000 commercial and Medicare lives, up from about 5,000 in 2011. PrimeCare now assumes full risk on all assigned patients in its HMO commercial contracts, and most patients in its Medicare Advantage contracts. In San Diego, PrimeCare gains access to additional patients through shared-risk arrangements with hospital systems that are capable of accepting institutional capitation; in contrast, the Inland Empire hospitals are less equipped to take institutional risk.

Without the strong physician affiliations and the comprehensive services of larger health systems, hospitals in this market have historically lacked focus or expertise in managing patient services across the continuum of care. However, they face growing pressures to contain costs and improve quality of care as part of the trend toward value-based payments in Medicare and some commercial insurance contracts. In addition, hospitals in this market face the particular pressures of a shrinking pool of commercially insured patients, health plans' development of high-deductible and narrow-network products, and growing competition with Kaiser. These pressures have led some hospitals to pursue organizational changes and relationships with other providers as first steps toward developing more-integrated care delivery systems capable of taking on population health management and value-based payment arrangements.

Key examples include:

- Two hospitals in the Coachella Valley — an affluent submarket — have formed medical foundations, with a particular focus on recruiting primary care providers. While medical foundations serve as a physician alignment strategy to both provide physicians an employment option and gain patient referrals in the current fee-for-service environment, the foundation model also aligns with preparations for value-based payments. Spurred by a change in executive leadership from outside the market and the hospital's strategy to position itself as a regional integrated delivery system and teaching facility, Eisenhower Medical Center formed Eisenhower Medical Associates five years ago. The foundation has grown rapidly to 140 physicians, or one-third of the hospital's medical staff. Also, Tenet's Desert Regional Medical Center started First Choice Physician Partners foundation as part of a statewide Tenet initiative in 2013, but its growth has been slower, with approximately a dozen physicians to date.

- Loma Linda is pursuing nascent efforts to both bring together parts of its own organization and affiliate with other providers. These efforts are aimed in part to reduce its high-cost structure as an academic medical center and to prepare for value-based payments. In addition to adding primary care and other outpatient capacity, Loma Linda is consolidating disparate administrative areas — both within the hospital and between the hospital and academic faculty practices — into a unified organizational structure known as "One Loma Linda." At the same time, it is working to bolster its high-end tertiary and quaternary services by working with several public and private hospitals on arrangements in which these other hospitals would take on the more routine cases, and they would refer more specialized cases to Loma Linda (see Safety Net section below). Overall, Loma Linda faces significant

challenges in its ability to transform into and compete as a cost-efficient integrated delivery system; its academic practice culture, limited primary care services, lack of clinical integration, and heavy reliance on fee-for-service payment — especially for high-end services — all act as barriers that will need to be addressed in the coming years.

Mainstream and Safety-Net Providers Overlap

Traditionally, the safety net for low-income uninsured people and Medi-Cal enrollees in the Inland Empire consisted primarily of two largely distinct systems separated by the Riverside/San Bernardino county line. Each was anchored by a relatively strong county hospital — Riverside County Regional Medical Center (now named Riverside University Health System Medical Center; see below) and San Bernardino's Arrowhead Regional Medical Center (ARMC) — and other hospitals played secondary safety-net roles. In addition to the county hospitals' primary care clinics, a number of community clinic organizations dotted the landscape, but compared to other California markets, this market lacked a robust set of community clinics with Federally Qualified Health Center (FQHC) status.[11] Federal status provides enhanced Medi-Cal payments, student loan repayment programs, and federal operational and capital grants (FQHC Look-Alike status provides the first two benefits but not grants). While access to care was better for people in Medi-Cal than those without coverage, overall access to primary and specialty care was considered inadequate for low-income people.

Several changes have occurred over the last three years, with varied impacts on overall access to care. Demand for care has increased as people have gained coverage under the Medi-Cal expansion. In response, there are signs that the safety net has broadened in certain ways, and some people are able to receive care closer to home. While the Medi-Cal managed care plans have long had provider networks in place that include most hospitals and many private physician practices, these hospitals and physicians recently have accepted more Medi-Cal patients, creating more overlap among the providers more traditionally focused on commercial and Medicare patients ("mainstream" providers) and the safety-net providers. Meanwhile, more community clinics gained FQHC status and have expanded. Still, the more mainstream providers reportedly are struggling to address emerging social service and behavioral health needs for which they have not been equipped to handle. Traditional safety-net providers are concerned about their ability to generate sufficient revenues to remain viable and continue serving people who remain uninsured.

Mainstream Providers Increase Medi-Cal Role

Some hospitals and physician practices have taken in more Medi-Cal patients as the insurance make-up of the population has shifted. With the erosion of commercial coverage (and the shift of commercially insured patients toward the Kaiser system), some providers have more capacity to treat Medi-Cal patients; the relatively low Medi-Cal payment rates became more acceptable and seen as better than no payment at all (i.e., compared to patients that were previously uninsured).[12] The LIHP programs that preceded the Medi-Cal expansion contracted with many private practice physicians; reportedly many of these patients stayed with these providers when the patients transferred to Medi-Cal. Also, Heritage Provider Network, traditionally focused on commercial and Medicare patients, has joined Molina's Medi-Cal network. As one hospital executive said, "Earlier, there were separate private physician offices and Medi-Cal offices; now there is more blending." In an example of this shift, one large physician group began accepting Medi-Cal patients to ensure sufficient patient volumes to retain its pediatric service.

Also, with Medi-Cal enrollment growth outpacing the size of its physician network, the local initiative, The Inland Empire Health Plan (IEHP), has made concerted efforts to attract more physicians. IEHP has temporarily continued to pay PCPs Medicare payment rates after the two-year boost granted by the ACA ended, and offers physicians supplemental payments if they meet performance metrics. The plan

reportedly pays specialists more than the standard Medi-Cal fee schedule. IEHP also established an $16 million fund to attract new physicians and mid-level providers to the area. The program, which began in early 2015, funds half of the first-year cost of a new physician or mid-level (up to a maximum amount) as a payment to the entity that contracts with or employs the new provider. The program has brought in more than 80 new physicians or mid-levels to date, and it has budgeted for at least 130 positions total.

Some of the smaller hospitals are also reaching out more to the Medi-Cal population. For example, Redlands Community Hospital added a primary care clinic and now operates two clinics in the community. Overall, safety-net roles appear to be broadening across hospitals, as evidenced by a decline in the proportion of total Medi-Cal discharges and outpatient visits that were provided by the dozen hospitals (the county hospitals plus others) that have traditionally served a safety-net role. This trend indicates that other hospitals provided relatively more services to Medi-Cal patients than before.[13]

Some hospitals have faced growing demand and capacity constraints in their emergency departments (EDs), stemming particularly from newly insured people unable to access timely primary care and other outpatient services in the community. ED visits rose 11% in the market overall between 2011 and 2014. In response to greater demand, Dignity's Community Hospital of San Bernardino, San Antonio Regional, and San Gorgonio Memorial Hospital have all opened new, larger EDs.

County Hospitals Adapt to Medi-Cal Expansion

Riverside University Health System Medical Center (RUHSMC) and Arrowhead Regional Medical Center (ARMC) struggled with a significant decline and shuffling of Medi-Cal patients right after the state expanded Medi-Cal. The hospitals had gained LIHP patients and revenues, but then both reportedly lost about half of their LIHP patients when they transitioned to Medi-Cal; these patients selected different providers as medical homes and/or were able to obtain follow-up care at other providers. In the words of one respondent, the hospitals "saw volatility never seen before, especially on the inpatient side." ED and ambulatory visits also declined, while specialty care visits reportedly didn't decline as much, likely because fewer Medi-Cal providers outside of the county provider network offer the same extent of specialty care. These changes contributed to the hospitals' financial challenges: RUHSMC's operating margin declined from –16% in 2011 to –27% in 2014, while ARMC's dropped from 9% to –15% in the same period.

In response, both hospitals have been working to increase the number of Medi-Cal enrollees who choose them as their primary care medical home. ARMC added an internal medicine primary care site and primary care providers on its hospital campus. RUHSMC focused on a three-pronged approach: to improve its scheduling, registration, and other aspects of customer service; to address more needs telephonically to reduce the demand for in-person visits; and to enhance the efficiency of its existing primary care capacity on-site and in the community.

The county hospitals largely recovered patient volumes as more people in the community gained Medi-Cal coverage after the initial transfer of the LIHP enrollees. The hospitals' payer mix has increasingly shifted toward Medi-Cal with concurrent reductions in uninsured patients, and their uncompensated care costs declined by about a quarter between 2011 and 2014. By 2015, Medi-Cal patients reportedly grew to about three-quarters of their business, and the percentage of uninsured patients fell to the single digits; together these changes have helped improve the hospitals' financial situations.

However, RUHSMC and ARMC face several pressures that threaten their future financial situation. As county hospitals, they receive cost-based Medi-Cal reimbursement for new Medi-Cal enrollees' hospital services. However, RUHSMC and ARMC no longer receive county general revenues to support the costs of serving other Medi-Cal and uninsured patients, and instead have relied on Medicaid

Disproportionate Share Hospital (DSH) payments, state realignment funds, and Medi-Cal waiver funds (including funds from the Delivery System Reform Incentive Payment program) — all of which have been on the decline. Although the federal government recently approved a new five-year Medi-Cal waiver for California, available funding is less than the previous waiver and will require public hospitals to adopt more value-based payment arrangements for Medi-Cal and uninsured patients. For RUHSMC and ARMC, this will be a significant shift away from their largely fee-for-service Medi-Cal payments and will require more attention to primary care and other strategies to serve patients efficiently.

To diversify their funding sources going forward, the county hospitals are trying to attract more Medicare and commercially insured patients, as well as retain their Medi-Cal patient base. In an effort to better integrate care and signal its academic affiliations, Riverside County's health services (the hospital, ambulatory care, public health, and mental health) now fall under the same new entity and leadership, the Riverside University Health System (RUHS). In San Bernardino, ARMC reportedly is engaged in a strategic planning process that involves improving its ambulatory footprint through a mix of increasing capacity and coordination with existing community providers, aligning more with physicians, and assessing the service lines on which they should focus.

In addition, IEHP is spearheading an effort to bring together the county hospitals and Loma Linda to develop a clinically integrated network for Medi-Cal enrollees. A main objective is to improve access to specialty care and keep patients within the counties; reportedly, appointment waits, coordination, and communication issues drive some people to seek high-end specialty care outside the market, in counties including Orange, San Diego, and Los Angeles. Keeping more of these services within the market would help both enrollee convenience and IEHP finances (i.e., to avoid paying out-of-network prices).

In IEHP's initiative, Loma Linda would focus more on tertiary and quaternary services, and the county hospitals would receive more of the more routine specialty care and hospitalizations. The county hospitals reportedly have started discussing how they might partner and rationalize services across their two campuses to focus on their core strengths and not duplicate services needlessly. An initial step is to adopt an integrated electronic health record (EHR) to share patient information; longer-term goals include potentially expanding the initiative to include patients with coverage other than Medi-Cal, and controlling costs, which might include more coordination and integration with community clinics. To date, RUHS is implementing Loma Linda's EHR and exploring joining a clinically integrated network with Loma Linda. ARMC also reportedly is evaluating such an arrangement.

Community Clinics Add Sites

Starting from a low base relative to need, the Inland Empire region has more community clinic capacity than it had three years ago. The number of community clinic sites (both FQHCs and non FQHCs, non-hospital operated) grew from approximately 40 to more than 50 between 2011 and 2014, an almost 40% increase; clinical staff increased by 50% (by approximately 80 full-time equivalents).[14] Facing increased competition with mainstream providers for physicians, community clinics have had to increase physician salaries. One health center director reported needing to divert funding from patient support services to meet salary expectations. Still, physicians composed a small portion of additional staff; clinics increasingly have relied on nurse practitioners and other nonphysician staff to enhance their capacity. In addition to general primary care capacity, clinics also are working to integrate behavioral health services into primary care settings to meet the growing need from the Medi-Cal expansion population.

In particular, the FQHC presence expanded, as existing FQHCs added care sites to underserved parts of the region and additional community clinics gained FQHC status. After RUHS's 10 FQHC sites, San Diego-based Borrego Community Health Foundation remains the largest

independent FQHC in the Inland Empire. It expanded from 6 to 10 sites in Riverside County between 2011 and 2014. Both starting with two sites, Inland Behavioral and Health Services in San Bernardino and Community Health Systems, which serves both counties, added one and two sites, respectively. Meanwhile, other existing FQHCs — including Neighborhood Healthcare and Clinicas de Salud del Pueblo in Riverside — added staff to increase the capacity of their existing sites. And two community clinics gained FQHC status over the last three years. One of these, SAC Health System, is adding an additional large clinic. Reportedly, plans are underway for additional new FQHC sites throughout the Inland Empire.

Many of the FQHC sites are located in Riverside and urban San Bernardino, while the more remote areas of San Bernardino continue to be served by small non-FQHC clinics and about a dozen federally qualified Rural Health Clinics. The Rural Health Clinics receive enhanced Medi-Cal reimbursement and are either independent or owned by physicians or hospitals; they have expanded modestly. They are located in areas such as Joshua Tree, Lake Arrowhead, and Twentynine Palms and reportedly overlap little with the service areas of the FQHCs and other clinics. In addition, unlike many local health departments in California (and across the US) that have retreated from providing primary care services, the County of San Bernardino has expanded its clinic presence to eight facilities widely dispersed throughout the county, three of which have FQHC status.

Some of the new FQHC sites are operated by Los Angeles-based organizations. Central City Community Health Center and Mission City Community Network, for example, added new sites or acquired existing struggling clinics or physician practices in otherwise underserved areas of the Inland Empire near the Los Angeles border.

The Medi-Cal expansion has resulted in significant shifts in patient mix among most FQHCs, with a jump in the proportion of Medi-Cal patients and a drop in the proportion of uninsured patients.[15] Still, new Medicaid patient volume has fallen short of some clinics' expectations. While the capacity expansions have helped address growing demands and relieved capacity constraints for some clinics, other clinics reportedly are still trying to gain more Medi-Cal patients. Some patients reportedly are in flux: A couple of clinic directors reported patients being inadvertently assigned to a county hospital by their health plan if they didn't actively choose a primary care provider, which took time to remedy with the Medicaid health plan to get the patients back. One respondent reported obtaining a subcontract with a county hospital to help absorb some of the Medi-Cal patients that the hospital could not accommodate in its primary care facilities.

Health centers continue to serve many uninsured patients. Most FQHCs had between 7% and 13% uninsured patients by 2014, but a few had considerably higher percentages. Since state funding to community clinics ended more than five years ago, FQHCs rely on their federal grants (which have been stable) to help support care for the uninsured. Still, to the extent that other providers are taking in more Medi-Cal patients but not uninsured ones, the concern is that community clinics — especially those without federal designation — will be left to care for the uninsured without sufficient resources to remain financially viable.

Impact on Access to Care

Assessing how access to care has changed over the last few years for low-income people in the Inland Empire is complex. On the one hand, the jump in Medi-Cal enrollment signals an increased demand for services as previously uninsured people have gained coverage and greater financial access to services. Indeed, the overall growth in ED visits reportedly reflects growing numbers of people seeking services but who may be unable to obtain timely access to primary, specialty, and behavioral health services through other venues. As mentioned with regard to specialty care, more people are likely seeking care from providers in neighboring counties.

The increased willingness of more mainstream hospitals and physicians to treat Medi-Cal patients, coupled with the

added community clinic capacity, suggests some low-income people are now better able to obtain health care services. Respondents indicate that the broadening of the safety net in this way also means some individuals can obtain services closer to home, which is particularly valuable in this very large geographic area with a dispersed population. Yet for reasons not entirely clear, the remaining uninsured population seems overlooked throughout the market; many low-income people — especially those who remain uninsured — likely continue to face significant challenges finding affordable and timely health care services and may go without needed care.

Issues to Track

- Will the market be able to expand needed hospital, clinic, and physician capacity, particularly in the most underserved parts of the region? Will the smaller hospitals obtain the capital to become seismically compliant (or receive reprieves from the state) and remain viable? Will community clinics obtain resources to continue to expand? How successful will the community's strategies to "grow" significant numbers of PCPs and psychiatrists be?
- To what extent will the region's physicians seek resources to remain independent, versus seeking employment or joining other models that offer less autonomy but more stability? What impact will these trends have on care delivery reform and movement to value-based payment?
- Will the large independent physician organizations that accept full risk be able to sustain these arrangements and make them viable over the long-term?
- How much more will Kaiser's presence, ability to attract physicians, and influence on the market grow? Will hospitals be able to develop integrated care networks and lower their cost structures enough to compete with Kaiser and fare well under value-based payments?
- How much more will demand for care and access to services change for the Medi-Cal population? How much more blurring of the line between mainstream and safety-net providers will the market see?
- To what extent will currently uninsured people gain coverage? To what extent will the counties and providers respond to the many people who remain uninsured, and what types of services will they provide?

ENDNOTES

1. *Medi-Cal Managed Care Performance Dashboard,* California Department of Health Care Services, September 17, 2015, **www.dhcs.ca.gov**. Among Medi-Cal plans in the state, IEHP performs slightly above average on a composite measure of plan performance on quality and satisfaction; by this same measure, IEHP performs significantly higher than Molina. The state's auto-assignment algorithm (used to assign new enrollees who do not choose a health plan) favors health plans that demonstrate higher performance in these areas, as well as greater use of safety-net providers and lower costs.

2. In an arrangement known as 1991 realignment, California counties receive funds from state vehicle license fees and sales tax revenues to support county health, mental health, and social services programs. With the expectation that many uninsured residents would gain Medi-Cal or other coverage under the ACA and the need for county medically indigent programs would decline, Assembly Bill 85 transfers either 60% or a formula-based percentage of each county's health fund to social services. Riverside and San Bernardino Counties are using the formula-based approach.

3. Under California Welfare and Institutions Code Section 17000, all California counties are responsible for providing health care services to their neediest residents, although counties have considerable discretion in setting eligibility criteria (e.g., income and immigration status) and the level of services they provide.

4. Annual Financial Data, California Office of Statewide Planning and Development, Healthcare Information Division, 2011 and 2014. Data reflect each hospital system's fiscal year.

5. Debra Gruszecki, "Murrieta: Kaiser Permanente Inks $9.3 Million Land Deal," *The Press Enterprise* (July 7, 2015).

6. Shea Johnson, "Hospital Master Plan Coming," *Victorville Daily Press* (December 8, 2015).

7. Jim Steinberg, "Work Begins on Loma Linda University Health's New Children's Hospital Tower," *The San Bernardino Sun* (October 1, 2015).

8. 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 a medical foundation model, physicians either contract with the foundation through an affiliated IPA or belong to a medical group that contracts exclusively with the foundation through a professional services arrangement. University of California hospitals, county hospitals, and some nonprofit organizations such as community clinics are among the entities allowed to employ physicians directly, through exceptions to the corporate practice of medicine prohibition.

9. "Inland Empire Seeks More Doctors to Treat Underserved Populations," *Kaiser Health News* (June 8, 2015).

10. Both PrimeCare and Heritage struggled to be financially successful in the Medicare Pioneer ACO Model. PrimeCare left the program in 2013 and entered the Medicare Shared Savings Program. Heritage is transitioning to the Next Generation ACO Model.

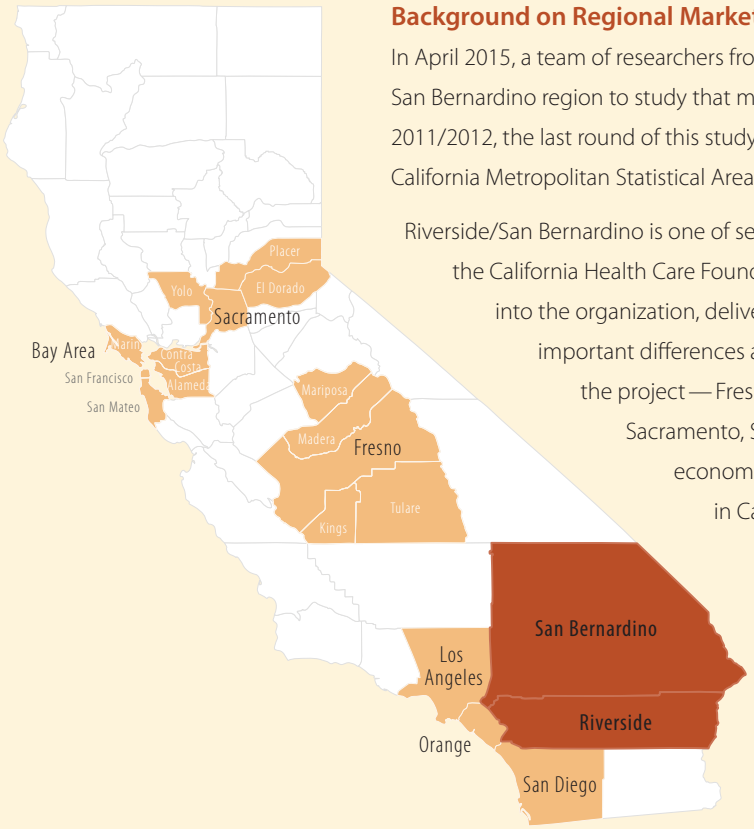
11. As another indicator of inadequate primary care capacity, Molina Healthcare operates 10 of its own primary care clinics for Medi-Cal patients, a practice it reportedly limits to counties with particularly inadequate capacity.

12. The Medi-Cal hospital fee program has helped hospitals financially as well. 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 to which federal matching dollars are added; these funds are then redistributed to hospitals based on their Medi-Cal inpatient days and outpatient visits. With payments beginning in 2010, the program has been renewed three times and currently is set to expire at the end of 2016. However, California voters could approve a ballot initiative in November 2016 that would eliminate the program's end date and require voter approval of further changes to the program.

13. Between 2011 and 2014, the proportion of overall Medi-Cal encounters provided by the 13 disproportionate share hospitals (DSHs) in the region (i.e., those recognized by the state as serving a disproportionate share of uninsured and Medi-Cal patients in their communities) declined from 60% to 50% for discharges and 65% to 56% for outpatient visits, per California Office of Statewide Planning and Development, Healthcare Information Division, Annual Financial Data, 2014. Data reflect each hospital system's fiscal year.

14. Annual Financial Data, California Office of Statewide Planning and Development, Healthcare Information Division, 2014. Does not include RUHS's 10 primary care sites that have FQHC status.

15. Ibid.



Background on Regional Markets Study: Riverside/San Bernardino

In April 2015, a team of researchers from Mathematica Policy Research visited the Riverside/San Bernardino region to study that market's local health care system and capture changes since 2011/2012, the last round of this study. 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 seven markets included in the Regional Market Study funded by the California Health Care Foundation. The purpose of the study is to gain important insights into the organization, delivery, and financing of health care in California and to understand important differences across regions and over time. The seven markets included in the project — Fresno, Los Angeles, Orange County,* 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.

Mathematica researchers interviewed over 200 respondents for this study, with 30 specific to the Riverside/San Bernardino market. Respondents included executives from hospitals, physician organizations, community clinics, Medi-Cal health plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.

*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

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