California Health Care Foundation

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Regional Market Report 2026: Inland Empire

California Health Care Almanac
Regional Markets Series

Table of Contents

California Health Care Foundation

Inland Empire: Expanded Health Coverage and Workforce Investments Yield Modest Access Gains

Summary of Findings

The Inland Empire counties of Riverside and San Bernardino span a vast area of Southern California, encompassing densely populated urban centers in the west; smaller cities and suburbs in the north, south, and central parts of the region; and sparsely populated expanses east to the Nevada border. The region's population continues to grow but remains poorer and has less formal education than California as a whole. More than 4 in 10 Inland Empire residents rely on Medi-Cal for health coverage, while commercial coverage has declined slightly in recent years. Reflecting the growing reliance on public insurance, community health centers (CHCs) have continued to expand their locations and services. Hospitals and physician groups remain relatively unconcentrated, with some altering service lines and strategies to adapt to payer incentives. Efforts to expand access and address physical and behavioral health needs show promise, but coming federal and state budget cuts and policy changes threaten recent gains.

The region has experienced a number of changes since the previous study in 2020–21 (see page 23 for more information about the Regional Markets Study). Key developments include the following:

- **Growing Medi-Cal and Covered California coverage helped lower the rate of uninsured people regionally.** Medi-Cal eligibility expansion under the federal Affordable Care Act (ACA), state-funded expansion of Medi-Cal to undocumented immigrants and people with unsatisfactory immigration status, and increased enrollment in subsidized commercial insurance through Covered California have helped lower the region's uninsured rate. Still, a larger share of Inland Empire residents remained uninsured than Californians overall.
- **The hospital and physician markets remain relatively unconcentrated.** Multiple hospital systems and independent hospitals operate across the sprawling region. Small independent physician practices continue to play a significant role regionally, with one respondent citing the Inland Empire as the state's "last frontier" for physician acquisition. Nonetheless, in recent years, national firms acquired two large medical groups in the region.
- **CHCs have continued to expand and play a central role in delivering primary care and outpatient services.** County-based networks of Federally Qualified Health Centers (FQHCs), along with other CHCs, provide care to a growing share of the region's population.
- **While health care workforce shortages remain widespread, local recruitment and retention investments are beginning to pay off.** Local medical schools and training and placement programs for advanced practice providers, nurses, and technicians aim to close workforce

gaps. However, meeting workforce needs, especially in remote, sparsely populated areas, remains challenging.

- **Investments in behavioral health care and efforts to better integrate physical, behavioral, and social services hold promise.** Many organizations in the region have embraced state efforts to transform Medi-Cal through improved care coordination and increased access to social services for vulnerable populations. Recent investments in behavioral health infrastructure will add much-needed inpatient capacity for people with serious mental illness and substance use disorders (SUDs). However, the need, compounded by ongoing workforce shortages, continues to outpace investments.
- **Recent policy shifts at both the federal and state levels threaten gains in access to care and threaten provider financial stability.** New state eligibility restrictions, federal administrative requirements, and federal funding cuts enacted in 2025 will decrease Medi-Cal enrollment, increase the uninsured population, and reduce hospital and CHC funding regionally in the coming years.

Market Background

Through the late nineteenth and early twentieth centuries, the Inland Empire was an agricultural hub, known for citrus, dairy, and winemaking. Now as then, when railroads in the area hauled oranges nationwide, the region's geographic location plays a central role in the economy. Once known as the Orange Empire, the region's proximity to major ports, railways, and highways makes the Inland Empire a major logistics hub today for warehousing and transporting products across the country and around the world.

A sprawling area in Southern California, San Bernardino and Riverside Counties are home to more than 4.7 million people (Table 1). By one estimate, the two counties have more than 4,000 warehouses covering nearly 40 square miles.[1] The thousands of logistics warehouses lining regional transportation corridors generate an estimated 600,000 truck trips daily, along with 50 million pounds of carbon dioxide.[2] Adding to the region's traffic and air-quality woes, almost 350,000 people commute from the two counties to work in nearby Los Angeles and Orange Counties, where wages are higher.[3] Along with logistics, the region's economy runs on health care, education, government, and retail, and to a lesser degree, manufacturing and tourism.

Spanning the borders of Kern, Los Angeles, and Orange Counties to the west and Arizona and Nevada to the east, the Inland Empire is vast — more than 27,000 square miles, larger than West Virginia. San Bernardino County, with more than 20,000 square miles, is the largest county in the contiguous United States and borders Inyo County to the north, while Riverside County borders San Diego and Imperial Counties to the south.

The region's population is split roughly evenly between Riverside County (2.5 million) and San Bernardino County (2.2 million). After experiencing rapid population and economic growth before the COVID-19 pandemic, population growth slowed to 2% between 2019 and 2023 but still outpaced the state, which saw a slight population decline (-0.2%) during that time.

Most people in the region live in the larger cities in southwestern San Bernardino County and northwestern Riverside County, south of the San Bernardino Mountains and east of the Santa Ana Mountains near Los Angeles. The Inland Empire's largest city is Riverside, with more than 330,000 residents, followed by San Bernardino, with almost 225,000 people. Farther east are more sparsely populated mountain and high desert areas, like Joshua Tree and the desert oasis of Palm Springs. The federal government owns 80% of the land in San Bernardino County, including Mojave National Preserve, and a substantial portion of Riverside County. The

small towns of Needles and Blythe, near the Arizona border, are about 200 miles from the Inland Empire's largest cities. The region's population skews younger, with a larger share of people under 18 (24.5%) and a smaller share of people 65 and older (14.4%) compared to statewide rates of 21.7% and 16.2%, respectively. The region's Latino/x population continues to grow faster than other racial/ethnic subgroups, accounting for 53.7% of the population in 2023 — more than 10 percentage points higher than the Latino/x share of the statewide population (40.4%). At the same time, a smaller proportion of the Inland Empire's residents were born outside the United States (22.3%) than statewide (27.3%). The region's White population declined slightly to 28.0% in 2023, while the share of Black residents remained essentially flat at 7.2% and the share of Asian residents grew slightly to 7.9%. While the region's share of residents with at least a high school diploma (82.7%) is close to the statewide average (84.6%), the proportion of residents with a college degree (24.1%) trails the state (36.5%).

TABLE 1. Population Characteristics
Inland Empire vs. California, 2023 Unless Noted

	INLAND EMPIRE	CALIFORNIA
POPULATION STATISTICS		
Total population (2024)	4,744,214	39,431,263
Share of state population	12.0%	100%
Five-year population growth	2.0%	-0.2%
AGE OF POPULATION, IN YEARS		
Under 18	24.5%	21.7%
18 to 64	61.1%	62.1%
65 and older	14.4%	16.2%
RACE/ETHNICITY		
Latino/x	53.7%	40.4%
White (non-Latino/x)	28.0%	34.3%
Black (non-Latino/x)	7.2%	5.6%
Asian (non-Latino/x)	7.9%	15.8%
Other (non-Latino/x)	3.2%	3.8%
BIRTHPLACE		
Outside the United States	22.3%	27.3%
EDUCATION (AMONG THOSE AGE 25 AND OLDER)		
High school diploma or higher	82.7%	84.6%
College bachelor's degree or higher	24.1%	36.5%
ECONOMIC INDICATORS		
Income below 100% federal poverty level	12.2%	12.0%
Household income $100,000+	43.0%	48.4%
Median household income*	$86,175	$96,334
Average (mean) household income	$110,909	$136,730
Unemployment rate	4.7%	4.8%
Households able to afford median-priced home (2024)	21.3%	13.6%

* A weighted blend of county-level median household income figures.

Sources: *Annual Estimates of the Resident Population for Counties in the United States: April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *Annual County Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023* (CC-EST2023-ALLDATA), *Annual County Resident Population Estimates by Selected Age Groups and Sex: April 1, 2010 to July 1, 2019; April 1, 2020*; and July 1, 2020, "US Census, American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth in the United States" (2019 and 2023), "ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County," "US Census, ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019," US Census Bureau; "Current Industry Employment and Unemployment Rates for Counties," California Employment Development Department; and "Housing Affordability Index - Traditional (Q2 2024)," California Association of Realtors.

About 1 in 8 people (12.2%) in the region had incomes below the federal poverty level in 2023 — or $30,000 for a family of four[4] — about the same as the statewide rate of 12.0%. However, fewer Inland Empire residents earn more than $100,000 annually (43.0%) compared with Californians generally (48.4%). Also, both median and average household incomes in the region substantially trail California overall. Housing affordability, once a major population draw, has declined sharply since 2019, with the share of households earning enough to purchase a median-priced home dropping from 44.9% to 21.3%.[5] Nonetheless, the share of Inland Empire households able to afford a median-priced home exceeded the statewide rate of 13.6%.

Regional Health Indicators Near State Averages

A greater share of Inland Empire residents report being in fair or poor health (16.2%) than the California average of 15.5% (Table 2). Still, this reflects improvement since 2018, when 19.9% of Inland Empire residents reported fair or poor health compared to 18.5% statewide. The region's infant mortality rate — 5.0 deaths per 1,000 live births — exceeds the statewide rate of 4.1 deaths per 1,000 births. However, Inland Empire residents are slightly less likely to have high blood pressure compared with Californians overall — 21.3% versus 21.9%.

TABLE 2. Health Status
Inland Empire vs. California, 2023 Unless Noted

	INLAND EMPIRE	CALIFORNIA
PHYSICAL HEALTH STATUS		
Fair/poor	16.2%	15.5%
Adults with an independent living difficulty*	6.0%	5.8%
Diabetes prevalence†	11.8%	11.3%
High blood pressure prevalence†	21.3%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	5.0	4.1
BEHAVIORAL HEALTH		
Anxiety prevalence†	10.3%	10.3%
Depression, bipolar, or other depressive mood disorders prevalence†	10.9%	10.5%
Opioid and other drug-related emergency department visits (per 100,000 population)	135.0	137.4
All drug-related overdose deaths (per 100,000 population)	31.0	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	10.9	10.1

* An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor's office, or shopping because of a physical, mental, or emotional condition.

† Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.

Sources: "AskCHIS," UCLA Center for Health Policy Research; "American Community Survey, 2023 5-Year Estimates, S1810, Disability Characteristics," US Census Bureau; "Healthcare Payments Data Measures Data (2018–2023)," California Department of Health Care Access and Information; "Infant Mortality," California Department of Public Health (CDPH); "County Health Status Profiles, 2024: Tables 1–29," CDPH, last updated August 8, 2024; and "California Overdose Surveillance Dashboard," CDPH, last updated May 19, 2025.

When comparing behavioral health indicators, Inland Empire residents report the same rates of anxiety as Californians generally (10.3%) and slightly higher rates of depression, bipolar, and other mood disorders (10.9% versus 10.5% statewide). The region has higher rates of drug-related overdose deaths (31.0 per 100,000 population versus 29.1 statewide) and suicide deaths (10.9 per 100,000 population versus 10.1 statewide).

Public Insurance Grows as Commercial Coverage Declines

The share of Inland Empire residents covered by Medi-Cal increased to 40.5% in 2023, up from 33.1% in 2019 (data not shown), and exceeded the 35.6% share of Californians overall with Medi-Cal in 2023 (Table 3). At the same time, the share of residents with commercial insurance, though stable statewide, declined regionally to 44.7% in 2023. Another 11.6% of Inland Empire residents had Medicare coverage in 2023, and 4.1% were dually eligible for Medicare and Medi-Cal. The share of people without health insurance declined both regionally and across California between 2019 and 2023, but 8.0% of Inland Empire residents remained uninsured in 2023 — higher than statewide (6.4%).

TABLE 3. Sources of Health Insurance
Inland Empire vs. California, 2019 and 2023

	2019		2023	
Coverages as Share of Population (Totals > 100%)*	Inland Empire	California	Inland Empire	California
Uninsured	8.9%	7.7%	8.0%	6.4%
Medi-Cal and Medicare dually eligible	3.2%	3.7%	4.1%	4.5%
Medi-Cal (no Medicare)	33.1%	28.6%	40.5%	35.6%
Medicare (no Medi-Cal)	11.2%	12.1%	11.6%	12.8%
Commercial	46.1%	50.6%	44.7%	50.8%

* Percentages may sum to more than 100% due to people being included in more than one category.

Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; "American Community Survey, 1-Year and 5 Year Estimates, S2701, Selected Characteristics of Health Insurance Coverage in the United States" (2019 and 2023), US Census Bureau; "By Medicare Dual Status, Certified Eligibles," California Department of Health Care Services; and Katherine Wilson, *California Health Insurers, Enrollment Almanac — 2025 Edition*, California Health Care Foundation, December 2025.

Covered California, the state's ACA marketplace, plays a small but important role in the Inland Empire. In 2023, Covered California accounted for 3.4 and 4.3 percentage points of commercial enrollment in the Inland Empire and in the state, respectively (data not shown). In 2025, the average monthly premium for the lowest-cost Covered California silver plan was less expensive ($394) regionally than statewide ($472) for a 40-year-old person (Table 4). Monthly premiums (unsubsidized) in the region consumed $2.27 of an hourly minimum wage and nearly 14% of a full-time minimum wage income in 2025, compared to statewide figures of $2.72 per hour and 16.5% of minimum wage income. Almost all Covered California enrollees in the Inland Empire (90.5%) receive a premium subsidy that reduces the monthly cost of coverage,

making the average net premium paid $129. By comparison, 89.4% of enrollees statewide receive a premium subsidy, paying an average net monthly premium of $134. Enhanced federal premium subsidies enacted during the COVID-19 pandemic expired on January 1, 2026, making premiums less affordable for approximately 173,000 Inland Empire residents who had received premium subsidies in 2025.[6]

TABLE 4. Covered California Monthly Premiums
Inland Empire vs. California, 2020 and 2025

	2020		2025	
Covered California Premiums	Inland Empire	California	Inland Empire	California
Lowest-cost silver monthly premium, 40-year-old*	$351	$398	$394	$472
Percentage higher/lower than California average	-11.7%		-16.5%	
Average annual premium increase, 2020–25			2.3%	3.5%
Per-hour wage amount needed to pay monthly premium†	$2.03	$2.29	$2.27	$2.72
Monthly premium as share of state minimum wage, full-time†	15.6%	17.6%	13.8%	16.5%
Percentage of members who receive premium subsidy			90.5%	89.4%
Average net monthly premium paid by those receiving subsidy			$129	$134
Median net monthly premium paid by those receiving subsidy			$72	$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes the person pays the entire premium (i.e., no subsidy to offset cost).

Sources: 2025 Covered California Data: *2025 Individual Product Prices*, Covered California; *2020 Individual Product Prices for All Health Insurance Companies*, Covered California; and *Active Member Profiles: June Profile* (2020 and 2025), Covered California.

The prevalence of medical debt in the Inland Empire, at 10.3% in 2022–23, dropped slightly from 11.4% four years earlier and remained just above the statewide rate (Table 5). However, among those with medical debt regionally, 60.7% owed more than $2,000 — a jump from 55.3% four years prior and a larger share than statewide.

TABLE 5. Medical Debt
Inland Empire vs. California, 2018–19 and 2022–23

	2018–19 POOLED		2022–23 POOLED	
Medical Debt	Inland Empire	California	Inland Empire	California
Prevalence (% of adults with medical debt)*	11.4%	10.8%	10.3%	10.2%
AMOUNT OF MEDICAL DEBT THEY ARE HAVING TROUBLE PAYING†				
Less than $2,000	44.7%	45.1%	39.3%	43.7%
More than $2,000	55.3%	54.9%	60.7%	56.3%

Note: Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.

* Prevalence figure is the percentage of people who answered yes to the question, "Ever had problems paying for self or household family's medical bills in past 12 months?"

† The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.

Source: "AskCHIS," UCLA Center for Health Policy Research.

Managed Care Grows in Medicare and Medi-Cal

The share of the population covered by Medicare has risen modestly both in the Inland Empire and in California in recent years (Table 6). Nearly two-thirds of Inland Empire Medicare enrollees are covered through private Medicare Advantage (MA) health plans, compared to about half of California Medicare enrollees overall. Among Inland Empire MA enrollees, Kaiser covers 32%, while SCAN and UnitedHealthcare each cover 15% (Table 7). Inland Empire Health Plan (IEHP), the region's largest Medi-Cal managed care plan, has served people dually eligible for Medi-Cal and Medicare since 2007 and continues to cover 7% of the region's MA enrollees.

TABLE 6. Medicare Enrollment Overview
Inland Empire vs. California, 2019 and 2024

	INLAND EMPIRE		CALIFORNIA	
	2019	2024	2019	2024
Total Medicare enrollment	671,402	759,982	6,239,477	6,899,496
Medicare as share of population	14.4%	16.0%	15.8%	17.5%
SHARE OF TOTAL MEDICARE				
Medicare Advantage	59.5%	64.9%	44.1%	51.2%
Original Medicare	40.5%	35.1%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

TABLE 7. Largest Medicare Advantage Health Plans and Market Share
Inland Empire, 2019 and 2024

Health Plan	2019	2024
Kaiser Foundation Health Plan	31.0%	32.0%
SCAN Health Plan	12.0%	15.0%
UnitedHealthcare of California	19.0%	15.0%
Inland Empire Health Plan	7.0%	7.0%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Reflecting California's continued expansion of managed care within Medi-Cal, nearly all (94%) of the more than two million Inland Empire residents with Medi-Cal are enrolled in managed care plans (Table 8). San Bernardino and Riverside Counties participate in the Medi-Cal Two-Plan model, under which most members choose between one publicly run local initiative plan and one commercial plan. IEHP, the local initiative plan, covers slightly under 80% of Medi-Cal enrollees in the two counties. Molina Healthcare of California, the commercial option in both counties, covers about 11% of Medi-Cal enrollees (Table 9).

In 2024, over the objections of IEHP and other local initiative plans and County Organized Health Systems, Kaiser began directly enrolling Medi-Cal members based on a statewide no-bid contract that enabled Kaiser to bypass subcontracting with IEHP and other local initiative plans.[7] Notably, unlike the other Medi-Cal health plans, Kaiser limits Medi-Cal enrollment to those who were Kaiser members within the preceding 12 months or who are immediate family members of a current Kaiser member. With that change, 9% of Riverside County and 10.1% of San Bernardino County Medi-Cal enrollees now obtain coverage directly from Kaiser, although many of them previously were enrolled with Kaiser via a subcontract with IEHP.

TABLE 8. Medi-Cal Enrollment Overview
Inland Empire vs. California, 2019 and 2024

	INLAND EMPIRE		CALIFORNIA	
	2019	2024	2019	2024
Total Medi-Cal enrollment	1,685,928	2,002,437	12,778,575	14,796,389
Medi-Cal as share of population	36%	43%	32%	38%
Share of Medi-Cal in managed care	84%	94%	82%	94%

Source: "Certified Eligibles by Delivery System and Plan" (August 9, 2024), California Department of Health Care Services.

TABLE 9. Largest Medi-Cal Managed Care Plans, by County
Inland Empire, 2019 and 2024

		MARKET SHARE BY COUNTY	
County	Plan	2019	2024
Riverside	Inland Empire Health Plan	87.9%	79.4%
	Molina Healthcare of California	11.7%	11.1%
	Kaiser Permanente	0.0%	9.0%
San Bernardino	Inland Empire Health Plan	90.2%	78.8%
	Molina Healthcare of California	9.3%	10.7%
	Kaiser Permanente	0.0%	10.1%

Note: Plan-level Medi-Cal managed care market share is as of December 2019 and December 2024.
Source: "Medi-Cal Managed Care Enrollment Report," (data through January 2025), California Department of Health Care Services.

IEHP Pursues Opportunities, Navigates Challenges

IEHP is generally well regarded by health care providers and community-based organizations. Respondents noted that among plans, "IEHP is the best" in partnering with hospitals to improve quality of care, that IEHP is a "good partner" in helping to identify members' preventive and screening needs, and that IEHP effectively communicates about patients whose circumstances put them on the fence between mild-to-moderate and severe behavioral health needs. IEHP data show that growing investment in pay-for-performance programs has contributed to steady improvement across many quality metrics.[8]

The plan's size and importance as the region's primary Medi-Cal payer, nonetheless, leave the plan open to some critiques.

Respondents reported that IEHP quality metrics sometimes are "a moving target" and cause unexpected swings in the nature and amount of provider quality incentive payments. Moreover, public hospital respondents reported that IEHP sometimes undervalues their contributions and is more attentive to demands from private hospitals and private hospital systems.

Also, IEHP faces federal scrutiny related to ACA Medicaid coverage expansions in 2014–16. The US Department of Justice filed suit in September 2025, after interviews for this study were completed, alleging that IEHP violated the federal False Claims Act by improperly retaining $320 million in Medicaid payments that should have been returned to the government. IEHP has disputed the allegations.[9]

With a goal of improving continuity of coverage and care for Medi-Cal members, IEHP entered the Covered California marketplace in 2024. Like most local initiative health plans in California, IEHP had not previously offered commercial coverage. The move required IEHP to navigate a new regulatory framework and risk-adjustment mechanisms. Under the ACA, Covered California annually adjusts payments to account for differences in enrollee health status and other factors by shifting payments from plans with lower-risk enrollees to plans with higher-risk enrollees.[10]

Thanks in part to being the lowest-cost silver plan in 2024 and 2025, IEHP quickly attracted a large share of Covered California enrollment, mostly at the expense of Blue Shield of California. As a result, IEHP reportedly succeeded in retaining members transitioning from Medi-Cal to Covered California. Although IEHP remains committed to the Covered California business line, the plan reported two types of "growing pains" related to this new offering. First, as IEHP's Covered California enrollment increased, the plan received multiple requests from providers to increase payments for this line of business, which IEHP resisted. Second, IEHP reported challenges conveying Medi-Cal members' health status information for risk-adjustment purposes because Medi-Cal information from physical assessments does not carry over to Covered California.

Hospital Market Remains Relatively Unconcentrated

The Inland Empire remains home to multiple hospital systems and independent hospitals, without notable changes or consolidation since the 2020–21 Regional Markets Study. In the densely populated western urban core, multiple hospital systems offer choice and compete for patients. In more sparsely populated submarkets, however, some systems or stand-alone hospitals play a dominant role. The region has a somewhat lower number of available beds per 100,000 residents than California overall — 173 and 198 beds, respectively (Table 10). At 3.0% in 2023, the average regional hospital net income (profit) margin trailed California hospitals overall (4.5%). Average operating expenses per adjusted patient day ($4,140) were below the state average ($5,117). While most hospitals in the region show solid financial performance, several face pronounced financial pressures, with some closing service lines like maternity care in response.

TABLE 10. Acute Care Hospitals Overview
Inland Empire vs. California, 2023

	Inland Empire	California
Number of facilities	38	334
Beds (available) per 100,000 population	173	198
Number of discharges	367,456	3,148,191
Net income margin	3.0%	4.5%
Operating expenses per adjusted patient day	$4,140	$5,117

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Operating expenses per adjusted patient day* equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

TABLE 11. Systems of Acute Care Hospitals
Inland Empire, 2023

Hospital System	Hospitals in System	Available Beds	Occupancy (Available Beds)	Share of Discharges in Region	DISTRIBUTION OF DISCHARGES BY PAYER TYPE			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
					Medicare	Medi-Cal	Commercial			
Loma Linda University Health	3	1,001	81%	15%	33%	46%	21%	1%	1.0	$6,038
Kaiser Foundation Hospitals	3	989	55%	13%	39%	13%	48%	3%	n/a	$5,607
Dignity Health	2	679	61%	7%	30%	58%	10%	-1%	1.7	$3,432
Tenet Healthcare	3	665	65%	7%	38%	44%	16%	7%	2.2	$3,124
Universal Health Services	3	641	74%	10%	44%	29%	25%	4%	1.5	$2,866
Inland Empire	**38**	**8,130**	**65%**	**100%**	**39%**	**38%**	**21%**	**3%**	**1.5**	**$4,140**
California	**334**	**77,339**	**64%**	**n/a**	**42%**	**31%**	**25%**	**4%**	**1.6**	**$5,117**

Notes: Hospital system designations exist for hospitals with at least three or more associated facilities in California. *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Current ratio* is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position. *Adjusted patient day* equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days. *Distribution of Discharges by Payer Type* may not add to 100% because *Other Indigent* and *Other Payers* are excluded.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

Multiple Hospital Systems Serve the Inland Empire

Almost 40 hospitals serve the Inland Empire, including county-owned hospitals in both Riverside and San Bernardino, along with an array of nonprofit, investor-owned, and district hospitals, which are publicly owned and governed by local communities (Table 11). In 2020, San Bernardino and Riverside Counties were the second- and third-least concentrated hospital markets in the state, behind only Los Angeles.[11] With no hospital mergers or acquisitions since that time, the Inland Empire's hospital market remains unconcentrated relative to most of the rest of California.

The region's major hospital systems include the following:

Loma Linda University Health, an academic medical center affiliated with the Seventh-day Adventist Church, has multiple hospitals with more than a thousand licensed beds. The system's flagship hospital, 482-bed Loma Linda University Medical Center, a Level I trauma center, is in San Bernardino County. The adjacent 364-bed Loma Linda University Children's Hospital is the region's only stand-alone pediatric specialty facility. Loma Linda also operates a 111-bed acute care hospital in Murrieta, about an hour south of Loma Linda in Riverside County, as well as a behavioral medicine center and small surgical hospital in Redlands in central San Bernardino County. As measured by inpatient discharges, Loma Linda had the largest market share regionally, at 15% in 2023. Across Loma Linda acute care hospitals, Medi-Cal accounted for 46% of discharges, while Medicare and commercial payers accounted for 33% and 21%, respectively.

Kaiser Permanente operates two large hospitals in Fontana and Riverside, as well as a 55-bed facility in Moreno Valley. Taken together, these facilities have 989 beds and account for 13% of discharges regionally, unchanged since 2014. A 152-bed expansion to the existing Kaiser Riverside hospital slated for completion in early 2027 will include renovations to the emergency department (ED) and labor and delivery suites while addressing state seismic requirements.[12] In recent years, Kaiser also expanded medical office facilities in towns beyond the urban core, including Wildomar in southwest Riverside County and Redlands.[13] In November 2024, Kaiser purchased a parcel in Hesperia, fueling speculation about

Kaiser's potential expansion in the high desert area of San Bernardino County.[14] A previous push to expand in the area hit a snag in 2022. A potential partnership with Providence, a nonprofit hospital system with a footprint across five western states, to build a new hospital in Victorville, about 10 miles north of Hesperia, was abandoned after the California attorney general imposed conditions the parties found untenable.[15]

Dignity Health operates two hospitals in San Bernardino County — St. Bernardine's Medical Center and Community Hospital of San Bernardino — with a combined 679 beds accounting for 7% of regional discharges, essentially unchanged since 2014. Commercial payers account for only 10% of discharges, and the system shows a small negative net income margin, consistent with the recent financial performance of the hospitals' parent system, CommonSpirit Health.[16] High poverty rates in communities surrounding the hospitals and increasing difficulty getting MA plans to authorize and pay for services were cited by one respondent as contributing to Dignity's weak financial performance.

Tenet Healthcare, a publicly traded company, operates three hospitals in the region, accounting for 7% of discharges: 388-bed Desert Regional Medical Center in Palm Springs, 145-bed JFK Memorial in Indio, and Hi-Desert Memorial in Joshua Tree with 59 acute beds and additional subacute capacity. Desert Care Network, the Tenet affiliate that manages the three Inland Empire hospitals, recently entered into a management agreement with the financially distressed San Gorgonio district hospital in northwest Riverside County to provide "resources and support that will help ensure the long-term strength and stability of the hospital."[17]

Universal Health Services, a publicly traded company with more than 40 acute care hospitals across the country, operates three hospitals in southwestern Riverside County through affiliate Southwest Health Care and accounts for 10% of the region's discharges. One hospital, Corona Regional Medical Center, recently announced labor and delivery services would end in 2026, citing decreasing birth rates and a desire to increase medical-surgical beds.[18]

Publicly traded **HCA Healthcare,** which has about 190 hospitals across the country, has just one hospital in the Inland Empire, 503-bed Riverside Community Hospital, which accounts for 7% of regional discharges. Since 2021, the hospital has added 20 ED beds and recently announced plans for a new 11-story patient tower with 220 medical-surgical beds and 54 intensive care beds.[19] With a payer mix of 39% Medicare, 37% Medi-Cal, and 20% commercial, Riverside Community Hospital posted a 12% net income margin in 2023.[20]

Public Hospitals Play Key Safety-Net Role

Along with Loma Linda and Dignity, two county-owned and operated hospitals play a major role in the Inland Empire safety net.

Arrowhead Regional Medical Center (ARMC) is San Bernardino County's core safety-net hospital. The 456-bed, university-affiliated teaching hospital has a payer mix of 61% Medi-Cal, 28% Medicare, and 7% commercial. In 2023, ARMC accounted for 6% of the region's discharges and posted a net income margin of 4%.[21] ARMC is a Level I trauma center; offers a comprehensive stroke center; and serves as the regional burn center for San Bernardino, Riverside, Inyo, and Mono Counties. The hospital operates five FQHCs that served over 10,000 patients in 2023 (unchanged since 2019),[22] 40 specialty outpatient clinics, and four mobile clinics. Also, in November 2025, ARMC opened a new 20-bed adolescent inpatient behavioral health unit.

Riverside University Health System (RUHS) is Riverside's county health system. The 439-bed RUHS Medical Center has a Level I trauma center, primary stroke center, and a

pediatric intensive care unit, as well as dozens of hospital-based primary and specialty care clinics, and accounted for 6% of the region's 2023 discharges. With a payer mix of 60% Medi-Cal, 24% Medicare, and 12% commercial, RUHS Medical Center's 2023 net income margin was -1%.[23] RUHS also operates a network of 13 FQHCs throughout the county that served over 95,000 patients in 2023 (an increase of about 50% since 2019).[24] As an alternative to ED services, RUHS recently expanded "express care" services and urgent care locations, some with extended hours, that offer same-day appointments. The RUHS organizational umbrella encompasses the county hospital as well as county departments of behavioral health and public health. This structure enables closer alignment of strategy and financial management than is possible in many counties, including San Bernardino, where ARMC's executive reports to the county board of supervisors, and the behavioral health and public health departments report to a county administrative officer.[25]

Hospitals Mostly Maintain Financial Footing, but Some Face Challenges

While most systems and larger hospitals in the Inland Empire have operated on relatively solid financial footing in recent years, some hospitals have not fared as well. Moreover, many respondents predicted broader financial challenges ahead. Two district hospitals, both in Riverside County, applied for and received loans under the state's Distressed Hospital Loan Program (DHLP) in 2023.

San Gorgonio Memorial Healthcare District, a 79-bed hospital in Banning, received a $9.8 million loan. According to the hospital's loan application, the funding will support plans to establish a dedicated stroke program and to recruit physicians to replace retiring providers at an updated, seismically compliant women's health center. The loan application also cited a high Medi-Cal caseload for perinatal care and a two-year lag in supplemental payments for such services, indicating that a DHLP loan would help bridge that gap.

Palo Verde Hospital, a 51-bed hospital in Blythe, received an $8.5 million DHLP loan, almost two-thirds of the hospital's annual revenue. Despite the loan, "a cascade of unforeseeable events" since 2023, including litigation, a cybersecurity incident, and resignation of key finance leadership, led the Palo Verde Healthcare District Board to suspend inpatient services in May 2025 and file for bankruptcy in September 2025.[26] The suspension of services means that Blythe's approximately 18,000 residents face a two-hour drive to either Indio or Needles for inpatient care.

Across California, a growing number of hospitals facing financial pressures, declining maternity volume, and pronounced workforce shortages have closed labor and delivery service lines in recent years.[27] Within the Inland Empire, Palo Verde Hospital closed maternity services in 2023; Hemet Global Medical Center, part of publicly traded KPC Health, in southern Riverside County closed a 12-bed labor and delivery unit in January 2025; and Corona Regional Medical Center has announced a 2026 closure. These closures are likely to worsen existing maternity care access challenges in more remote parts of the region.[28] Already lagging the state in infant mortality and with significant disparities for Black mothers, efforts to improve birth outcomes may be stymied by lack of accessible maternity care.[29]

Irrespective of recent financial results, virtually all hospital respondents reported increasing concerns about managing certain aspects of their underlying costs. Specifically, they cited state-mandated minimum wage laws, nurse staffing ratios, seismic safety requirements, behavioral health data reporting requirements, and accreditation processes as straining hospital finances. Several hospital respondents noted that wage and benefit increases negotiated with organized labor have reduced net income and profit at some facilities in recent years. Most respondents expected financial pressure on hospitals to ratchet up as federal Medicaid cuts

roll out and California policymakers confront related budgetary trade-offs.

One respondent said that hospitals increasingly "have to think through what services are providing any margin" as they balance community needs with financial viability. For example, some systems were exploring consolidation or elimination of service lines such as pediatrics and gastroenterology. Looking to the future, several respondents speculated about potential ripple effects from hospital closures or service-line reductions. With many of the larger hospitals in the Inland Empire already experiencing high ED volume and high inpatient occupancy levels, additional demand and potentially higher-acuity patients might further strain inpatient resources.

CHCs Grow and Expand Services

Along with the county-run CHCs, more than 50 other CHCs serve as core providers of outpatient care in the region, particularly in less populated areas and for people with lower incomes (Table 12). Two-thirds of CHC patients in the region have incomes below 100% of the federal poverty level, and Medi-Cal provides 86% of CHC revenue regionally, higher than the statewide share of 78%.

TABLE 12. Community Health Centers Overview
Inland Empire vs. California, 2023

	Inland Empire	California
Number of sites	56	1,139
Patients with incomes under 100% of federal poverty level	67%	70%
Patients per capita	0.10	0.21
Change from 2018	43%	40%
Encounters per capita	0.31	0.69
Change from 2018	19%	35%
Medi-Cal as share of net patient revenue	86%	78%

Notes: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.
Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

Operating multiple sites across the Inland Empire, several CHC systems also have sites in counties adjacent to the Inland Empire, including Los Angeles, Orange, and San Diego. Some of the largest CHC organizations in the Inland Empire are listed below.

DAP Health, a Palm Springs–based FQHC, accounted for the largest number of patient encounters in 2023 (Table 13), following its acquisition of San Diego–based Borrego Health, which declared bankruptcy in 2022 following allegations of fraud and mismanagement.[30] Established in 1984, DAP Health initially focused on health care needs emerging from the AIDS epidemic. Historically, DAP's patient population was older, with more complex medical conditions than that of most regional CHCs. As a result, DAP developed robust wraparound social services for patients. For example, DAP developed single housing units to accommodate 80–100 people near its Palm Springs facilities. With the acquisition and integration of the former Borrego clinic sites that served more families, DAP has increased primary care and pediatric and maternity services.

SAC Health System has 12 sites across San Bernardino and Riverside Counties, including two in rural communities. The CHC's integrated services include primary care; behavioral health; dental; and more than 40 specialties such as cardiology, endocrinology, and dermatology. Since 2020, SAC Health has expanded from three small clinics to a regional network. Further growth will accompany the forthcoming opening of the 250,000-square-foot Brier campus in San Bernardino, which will serve as a hub for specialty, dental, and behavioral health services, as well as residency training programs affiliated with Loma Linda University Medical School. The organization operates a community resource center that provides a range of resources addressing social determinants of health. SAC has a long-standing relationship with Kaiser, and at one time explored serving as Kaiser's exclusive FQHC partner throughout the state. That possibility

ended with Kaiser's direct Medi-Cal contract; however, some Kaiser enrollees continue to receive care at SAC sites.

Neighborhood Health Care operates multiple sites in Riverside and San Diego Counties. The CHC organization opened a new Riverside site in 2021 that includes a Program of All-Inclusive Care for the Elderly, or PACE, which helps people — typically seniors eligible for both Medicare and Medicaid — meet their health care needs in the community instead of entering a nursing home or other facility.[31]

Community Health Systems, Inc. (CHSI) operates several sites in Riverside, San Bernardino, and San Diego Counties. Magnolia Community Health Center in the city of Riverside is the largest site. CHSI used COVID-era funding to obtain two mobile units, with one outfitted primarily for dental services, to serve Inland Empire communities. CHSI plans to open a new brick-and-mortar site in the high desert area of Apple Valley by early 2026.

Planned Parenthood offers reproductive and primary care in both Riverside and San Bernardino Counties. A provision of the federal House Resolution (HR) 1 enacted in July 2025 ended Medi-Cal payments for primary care and non-abortion services to organizations providing abortion care. Following unsuccessful legal challenges, in October 2025 Planned Parenthood ceased to offer primary care services in Upland and San Bernardino, sites that had once provided primary care to 3,700 Inland Empire residents.[32] Although Planned Parenthood no longer receives federal Medicaid funding for any services, California has provided additional short-term funding, and Planned Parenthood accepts self-pay patients and some other types of coverage.[33]

Small Physician Practices Strive to Remain Independent as National Firms Make Inroads

Across California, the number of independent physician-owned practices has declined over the past five years.[34]

TABLE 13. Largest Community Health Center Systems
Inland Empire, 2023

Organization	Encounters	Patients Under 100% Federal Poverty Level	Medi-Cal as Share of Net Patient Revenue
DAP Health	219,421	61%	83%
SAC Health System	202,517	54%	97%
Neighborhood Healthcare	189,462	62%	95%
Community Health Systems	134,520	59%	82%
Planned Parenthood of Orange and San Bernardino Counties	89,075	39%	77%
Planned Parenthood of the Pacific Southwest	84,558	61%	74%
Inland Empire	**1,457,629**	**67%**	**86%**
California	**26,871,453**	**70%**	**78%**

Notes: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

Consolidation of physician organizations is often billed as increasing clinical integration and coordination that will improve quality and efficiency, but those promises have not materialized. Instead, consolidation often drives up costs and worsens affordability challenges.[35] Despite predictions that financial and demographic headwinds would encourage consolidation among the region's large independent practice associations (IPAs) and medical groups,[36] and despite two notable acquisitions in recent years, the physician market regionally remains relatively unconcentrated. Whether this represents a beacon of hope for independent practice or a market opportunity depends on perspective; one observer noted that within California, the Inland Empire remains the "last frontier" for physician practice acquisition.

Medical Group Acquisitions and Reactions

Astrana Health is a California-based, publicly traded organization with clinicians in three states that holds risk-based contracts across commercial, Medicare, and Medicaid lines of business.[37] Like many large health care provider organizations, Astrana includes not just physician organizations that deliver clinical care but also a management services

organization that provides administrative and operational support to medical practices. Previously, Astrana's corporate predecessor, Apollo Med, had acquired Alpha Care Medical Group, a 1,000-physician IPA serving the Inland Empire. [38]

In 2025, Astrana acquired California-based Prospect Medical Group, which includes physicians across the Inland Empire and other parts of Southern California; subsidiaries include Pomona Valley Medical Group, which serves western San Bernardino County (and eastern Los Angeles County) and Upland Medical Group in Ontario in San Bernardino County.[39] When finalized, the transaction will affect nearly 200,000 Inland Empire residents cared for by these medical groups.[40] One respondent expected that the Astrana Health acquisition would enable the acquired physician organizations to exert more leverage for higher health plan payments than would have been possible under prior ownership arrangements.

Optum, the medical services arm of UnitedHealth Group, employs or is affiliated with about 5,500 primary care providers and 13,000 specialists in California.[41] In the Inland Empire, Optum had previously acquired Inland Faculty Medical Group, PrimeCare, and North American Medical Management.[42] Optum's reach in the region grew again in 2021 with the acquisition of Redlands-based Beaver Medical Group, with over 200 physicians and an affiliated management services organization, Epic Management.[43] Respondents offered varied assessments of the impact of Optum's acquisitions. Some noted that Optum provides business structures and data that encourage more consistent clinical performance and reduce administrative burden on clinicians. Others observed that appointment wait times and provider availability have worsened under Optum ownership.

Optum's increasing presence in the Inland Empire has sparked at least one direct response: the 2024 establishment of Community Alliance Medical Group, a group of 13 primary care physicians who had previously been part of Beaver Medical Group. With locations in Beaumont, Redlands, and Yucaipa, the group has established contracts with commercial and MA plans as well as IEHP. The group's stated goal is to maintain professional autonomy and keep any financial gains within the local community.[44] Community Alliance Medical Group is led by and received initial financing from a few local physicians who position the group as an explicit alternative to for-profit, corporate medicine.

Independent Practices Retain an Important Role

Fifty-six physician organizations serving residents in San Bernardino and Riverside Counties were registered in 2024 with the California Department of Managed Health Care as risk-bearing organizations.[45] Only 3 of the 56 are owned by a hospital or health care system, and 39 reported managing fewer than 5,000 patients. Physicians contracting with IEHP for Medi-Cal business are more likely to do so through direct contracts with IEHP than via delegated networks or IPAs.[46] All of these indicators align with respondent reports that small, independent medical practices remain common in the Inland Empire. Several respondents expressed general concern about the growing threat of corporate acquisition and the potential for private equity investment to gain ground in the region, but beyond Astrana Health and Optum, offered no specific examples.

Respondents in independent practice voiced a deep commitment to maintaining autonomy so they could deliver care consistent with their values. Independent practices reported that maintaining financial viability requires nimbleness and experimentation. Observing that Medicaid and Medicare payments have not kept pace with costs and expressing deep concerns about further financial instability due to federal and state Medicaid cuts, physician practices expected to make increasingly tough choices to maintain independence. Some are prioritizing MA business, pointing to relatively generous payment levels and the potential for quality incentive payments. Others are trying to persuade commercial payers,

Covered California, and Medi-Cal to better recognize the value of independent practice and to shift compensation structures accordingly.

Workforce Shortages Still a Significant Challenge

The Inland Empire's physician supply has grown substantially in recent years, with primary care and specialty physicians per 100,000 population rising 20% and 38%, respectively, from 2015 to 2023 levels (data not shown).[47] Respondents expressed optimism that constructive collaborations and a range of investments will continue to expand the health care workforce in the Inland Empire. However, with 229 physicians per 100,000 population, the Inland Empire still has far fewer physicians than the statewide figure of 358 (Table 14). The gap holds across primary care and specialty physicians when examining physicians working more than 20 hours weekly. Regional health care leaders repeatedly cited physician shortages as a significant and chronic challenge across a range of specialties, including obstetrics, gastroenterology, and neurology. Physician shortages reportedly contribute to longer appointment wait times and hinder patients and physicians from establishing ongoing relationships, which can disrupt continuity of care. The number of psychiatrists per 100,000 population in the region also is considerably lower than the statewide figure, with one respondent characterizing the shortage of psychiatrists and other behavioral health care providers as "dire." Of note, statewide figures are not a recommended benchmark but rather a baseline for comparison of regional disparities in supply.

As in California as a whole, the Inland Empire's health care workforce does not match the diversity of the region's population. One-half of the region's population is Latino/x, but only 1 in 10 physicians and less than one-third of other providers are Latino/x (Table 15).

TABLE 14. Health Care Workforce Supply
Inland Empire vs. California, 2024

	Inland Empire (Percentage of Statewide Average)	California
LICENSED PROVIDERS PER 100,000 POPULATION		
LICENSE GROUP*		
Physicians	229 (64%)	358
Advanced practice providers	116 (91%)	128
Nurses	1,529 (113%)	1,353
Behavioral health providers	300 (78%)	384
PHYSICIAN DETAIL BY SPECIALTY AND HOURS WORKED†		
PHYSICIANS PER 100,000 POPULATION		
Physicians working 20+ hours/week	200 (68%)	294
Primary care	85 (72%)	118
Specialty	115 (65%)	176
Psychiatry	11 (64%)	18

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians* are MDs and DOs; *advanced practice providers* are nurse practitioners and physician assistants; *nurses* are licensed vocational nurses and registered nurses; *behavioral health providers* are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.

Source: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025.

TABLE 15. Physician and Health Workforce Characteristics
Inland Empire, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
RACE/ETHNICITY OF PROVIDERS*					
Latino/x, any race	10.3%	22.6%	30.8%	30.8%	53.7%
White, non-Latino/x	37.9%	33.2%	27.1%	27.1%	28.0%
Asian, non-Latino/x	42.7%	25.2%	26.7%	26.7%	7.9%
Black, non-Latino/x	5.2%	13.2%	9.7%	9.7%	7.2%
LANGUAGES SPOKEN†					
English only	51%	57%	57%	67%	
Spanish	13%	20%	19%	26%	

Notes: License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians* are MDs and DOs; *advanced practice providers* are nurse practitioners and physician assistants; *nurses* are licensed vocational nurses and registered nurses; *behavioral health providers* are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.

* Not shown: Other, non-Latino/x.

† Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023* (CC-EST2023-ALLDATA), US Census Bureau.

Many Workforce Efforts, yet Challenges Remain

Respondents universally acknowledged health care workforce gaps and recruiting and retention challenges across the Inland Empire. While workforce concerns prevail throughout the region, they are even more acute in outlying rural areas. In response to decades-long workforce shortages, many educational institutions, organizations, and local leaders have long invested in training, recruitment, and retention efforts. One respondent noted that, more than in some other parts of the state, there is robust and innovative activity across the range of health care professionals, including physicians, physician assistants, nurses, and medical technicians. Although workforce initiatives are not centrally organized, knowledge is readily exchanged among the interested parties. When progress is made by one organization or within one professional category, respondents across the region are eager to claim a win.

Expanding the clinician supply. Many of the medical and professional schools serving the Inland Empire have expanded programs or increased efforts to encourage graduates to stay and work in the region. The 50-student inaugural class of the University of California, Riverside (UCR) School of Medicine graduated in 2017; class sizes now stand at about 90 students per year. UCR admission criteria reflect not only academic rigor but also community needs, emphasizing recruitment of students who are first-generation, non-native English speakers, and those with lower incomes. More than a third of residency placements for the 2025 class were in the Inland Empire, with a similar share of graduates over the past five years continuing to work in the region.[48] About a third of current UCR medical students receive scholarships funded by donors, foundations, and corporations that cover tuition and fees in exchange for students committing to practice in the Inland Empire for five years.

UCR recently announced plans to build an expansive multispecialty ambulatory care center, followed by a 250-bed teaching hospital.[49] To date, without its own hospital, UCR has relied on community affiliates to provide clinical training sites for students. Respondents welcomed the possibility that the expansion might improve access to specialty and subspecialty care but speculated about a potential negative impact on payer mix at other area hospitals as well as increasing competition for an already-strained health care workforce.

Several other schools contribute to the supply of physicians and other health professionals in the region. Loma Linda University School of Medicine, consistent with its Seventh-day Adventist ties, emphasizes preventive medicine. The California University of Science and Medicine, affiliated with ARMC for clinical internships, has begun to graduate classes of more than 100 medical students and aspires to address the needs of underserved Inland Empire residents.[50] Western University of Health Sciences, in eastern Los Angeles and just 10 miles from the Inland Empire's core population, offers training in osteopathic medicine with an emphasis on primary care. Physician assistant and nurse practitioner training programs are also available at several locations in the region, although a proposed physician assistant program at California State University, San Bernardino, recently failed to gain accreditation.[51] New collaborations to support community-based residencies are also on the horizon. Innercare, a CHC network operating in Riverside's Coachella Valley and Imperial County, recently announced a family medicine residency program in partnership with Eisenhower Health and DAP Health.[52]

Since 2020, IEHP's Healthcare Scholarship Fund has provided more than $38 million in aid for 239 medical and psychiatric nurse practitioner students at UCR, California University of Science and Medicine, and Loma Linda University. Recipients commit to serving the Medi-Cal population in Riverside or San Bernardino Counties for at least five years after graduation.[53] Another IEHP initiative includes a network expansion fund that awards grants to offset the costs of hiring primary

care and specialty physicians and advanced practitioners with the condition that they remain in the IEHP provider network for at least three years.[54] The Inland Empire Foundation for Medical Care, affiliated with the Riverside County Medical Association, provides one-year population health fellowships intended to improve practice performance and increase physician retention in the Inland Empire.[55]

IEHP reported improvements between 2022 and 2024 in appointment availability, attributing the gains in part to workforce investments. Over that period, behavioral health urgent and nonurgent appointment availability improved, and IEHP now meets California Department of Managed Health Care standards for nonurgent appointments. Primary care provider nonurgent appointment availability also improved, although availability of urgent primary care appointments remained flat. Specialty care appointment availability also has shown modest improvement.[56]

Building pipelines and recruiting from within. To address workforce needs, many organizations participate in pipeline programs to encourage more young people to consider health care jobs. For example, the Inland Empire Health Education Center, part of the Community Health Association of the Inland Southern Region, offers a community health training certification program intended to strengthen and diversify the health workforce. Additionally, Tenet hospitals in the region are partnering with College of the Desert to stand up a radiology technician training program. UCR also offers pathway programs to recruit, advise, and mentor high school and college students interested in health care careers.[57] Support from the California Department of Health Care Access and Information scholarship program helps UCR students interested in nursing, dentistry, and other allied health fields pursue training.

Multiple respondents described efforts to "recruit from within" by supporting health care workers to obtain additional training and certification. Several hospitals prioritize support for recent nursing graduates to acquire on-the-job experience and guidance. Several respondents emphasized the importance of supporting nursing and ancillary staff to work "to the top of their scope" of license. A few organizations reported that recognizing individual contributions and "caring for the caregiver" are key retention strategies. Leaders in faith-based health organizations also reported that appeals to workers' values and mission alignment helped with recruitment and retention.

Despite these multipronged strategies, respondents see a long, challenging road ahead to meet regional workforce needs. The sense that lower wages and more limited employment opportunities for spouses put the Inland Empire at a competitive disadvantage relative to Los Angeles and Orange County labor markets was widespread. Retirements and reductions in work effort that accelerated during the COVID-19 era have slowed but not ended, according to some respondents. Worker expectations regarding working conditions, such as four 10-hour days or partially remote work, particularly for behavioral health professionals, do not always align with the needs of provider organizations. New minimum wage mandates in health care have added to workforce challenges, with the impact extending beyond those in lower-wage jobs or organizations immediately affected to other workers who expect to maintain pay differentials or who may leave for higher-paying opportunities at other organizations.[58]

With workforce gaps an acknowledged challenge, several respondents commented on other ways to improve access to care. A few hoped that artificial intelligence tools might improve existing providers' satisfaction and productivity, potentially stemming the tide of imminent retirements. One health plan highlighted in-home wellness visits and remote prenatal visits as tools to keep patients connected even when provider shortages, travel time, or federal immigration raids make them reluctant or unable to access care.

CalAIM Initiatives Welcomed, Implementation Reviews Mixed

The state launched the CalAIM (California Advancing and Innovating Medi-Cal) initiative in 2022, with major changes to many aspects of the Medi-Cal program planned for phased implementation over several years.[59] Two foundational aspects of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS) services. A new Medi-Cal benefit, ECM provides resources for care coordination and care management for patients with complex needs. CS services, which are optional for managed care plans to offer, expand Medi-Cal beyond traditional health care services, adding services for health-related social needs such as housing supports, medically tailored meals, and sobering centers.[60] Medi-Cal managed care plans are responsible for implementing and coordinating these services. These CalAIM programs have prompted more social service organizations to contract with Medi-Cal managed care plans and more health care organizations, especially CHCs, to offer social services directly or through partnerships.

In the Inland Empire, almost 30,000 people, or 1.6% of Medi-Cal enrollees, received ECM services in 2024 — similar to the 1.5% statewide rate (Table 16). In contrast, enrollment for CS services was lower regionally than statewide — 0.9% versus 1.9%. In the fourth quarter of 2024, the most-used CS service regionally was housing transition navigation (9,864 enrollees), followed by medically tailored meals (2,244 enrollees), and housing tenancy and sustaining services (1,700 enrollees). Other CS services used by more than 200 members included housing deposits (957), recuperative medical care (548), short-term posthospitalization housing (324), and personal care and homemaker services (237).[61]

TABLE 16. Medi-Cal and CalAIM
Inland Empire vs. California, 2024

	Inland Empire	California
ENHANCED CARE MANAGEMENT (ECM) ENROLLMENT*		
ECM enrollment	29,820	206,501
Share of Medi-Cal managed care enrollees receiving ECM	1.6%	1.5%
COMMUNITY SUPPORTS (CS) ENROLLMENT†		
CS enrollment	16,224	258,141
Share of Medi-Cal managed care enrollees receiving CS	0.9%	1.9%

* ECM enrollment is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.

† CS enrollment is the number of members receiving services in the 12 months of the reporting period ending September 2024.

Source: *ECM and Community Supports Quarterly Implementation Report* (data through September 30, 2024), California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.

Mixed Reviews of ECM and CS

Many respondents indicated that the Inland Empire had a firm foundation on which to implement CalAIM programs. CHCs described long-standing efforts to connect patients with social services, adding that CalAIM goals are consistent with their missions as well as the missions of local community-based organizations. Well before 2022, IEHP implemented and evaluated programs to provide permanent supportive housing and to manage and coordinate patient care through robust relationships with community organizations for service delivery.[62] Aligned with CalAIM goals, Molina, for example, works with the California Medical Association to support Medi-Cal providers in improving care in women's and maternity health, behavioral health, chronic disease, and child and adolescent preventive health.[63] However, aligned goals did not guarantee smooth implementation of CalAIM programs.

Both health plans and providers reported uneven experiences with the ECM rollout, noting a lack of clear California Department of Health Care Services (DHCS) reporting requirements and a substantial "compliance burden." Initially, IEHP had trouble recruiting enough ECM providers, but more recently, provider interest has exceeded the plan's

capacity to onboard and train new providers — a situation characterized as "growing pains." CHCs noted that payment rates are "robust" and enable them to "do more for patients." Most respondents reported that ECM has improved important outcomes, including better transitions across the care continuum and improved patient adherence with treatment recommendations, particularly among very high-risk patients. Some reported that ECM services, supported by a strong health information exchange platform and multistakeholder collaboration around data sharing, have improved access to care and have begun to reduce unnecessary hospital admissions.

Respondents also reported mixed experiences related to implementation of CS services. For example, a CHC respondent reported that despite having a robust in-house community resource center before CalAIM, their organization could not justify the effort needed to realign worker titles and activities to qualify for CalAIM reimbursement. Respondents also noted that data sharing between community organizations and Medi-Cal managed care plans lags for smaller organizations and grants-based nonprofits that did not have business relationships with plans before CalAIM implementation. Health plans invested considerable effort to code, price, and monitor utilization of new CS services yet don't have a clear view of their impact on member health.

Similarly, respondents offered skeptical or uncertain assessments of the potential benefits of many CS services. One respondent noted that CS funding for the first time provided payment for services in a sobering center but that "it was not the game changer we'd hoped" due to a slow rollout, service exclusions, and DHCS reporting requirements. Other critiques noted that medically tailored meals were not sufficiently customized for patient medical needs to reasonably affect health outcomes, that housing navigation offers limited value if there is an inadequate underlying supply of affordable housing, and that limited oversight and accountability allow some organizations offering CS services to capture payments without paying much attention to improving outcomes.

Several respondents framed observations about CalAIM within the broader context of providing appropriate care for the whole person across the lifespan, including supporting people before they develop serious health conditions. For example, to help overcome the ill effects of isolation, an IPA in a less populated area of the region hosts structured opportunities for social engagement for patients and the larger community. Similarly, Blue Zones Project Riverside, a partnership including IEHP, Kaiser, Molina, RUHS, and many other public and private entities, was established recently to implement a multipronged strategy to improve quality of life and to lower health care costs by making "the healthy choice the easy choice."[64] RUHS also points with pride to a homegrown Whole Person Health Score used to demonstrate progress in engagement and overall well-being among the system's patient population.[65]

Behavioral Health Initiatives Support Service Expansion

Over the last several years, California has implemented a series of investments aimed at transforming the public behavioral health care system. Policy initiatives to strengthen the behavioral health care continuum include CalAIM Behavioral Health Payment Reform, BH-CONNECT (Behavioral Health Community-Based Networks of Equitable Care and Treatment), the Children and Youth Behavioral Health Initiative (CYBHI), and investments in infrastructure and housing through Behavioral Health Continuum Infrastructure Program (BHCIP) grants. In addition, Proposition 1, which voters approved in March 2024, made significant changes to the Mental Health Services Act of 2004 and authorized $6.4 billion to build additional behavioral treatment facilities and supportive housing. In most cases, county behavioral health agencies are tasked with implementation of these initiatives.

Both Riverside and San Bernardino Counties were early adopters of Medi-Cal behavioral health program changes, beginning with adoption of the Drug Medi-Cal Organized Delivery System (DMC-ODS) near its inception. Respondents in both counties noted that DMC-ODS enables them to deliver more services and to get higher payment rates; one respondent noted DMC-ODS has been helpful in diverting people with SUDs from crowded jails.

In recent years, CHCs, hospitals, community organizations, and counties have expanded behavioral health services in a variety of ways. For example, CYBHI has supported additional services and better coordination of school-based services in both counties. SAC added a clinic site focused on medication-assisted treatment for SUDs, adopted warm handoffs from primary care and obstetrical providers to in-house mental health providers, expanded residencies for child psychiatrists, and developed training programs for licensed clinical social workers and marriage and family therapists. Loma Linda University Hospital is establishing adult and youth emergency psychiatric assessment, treatment, and healing units that provide an alternative to hectic EDs and smooth the transition of patients experiencing a mental health crisis to an appropriate care setting. As previously mentioned, ARMC reopened an adolescent inpatient behavioral health unit, and San Bernardino County created youth clubhouses run by peers and family advocates to support engagement and mental wellness.

Behavioral Health Integration Advances, Particularly in Riverside County

Medi-Cal divides responsibility for behavioral health care between Medi-Cal health plans, which are responsible for non-specialty mental health services, and county governments, which are responsible for specialty mental health and SUD services. This system has long been problematic for patients and providers, since it creates an artificial divide between monitoring and managing behavioral health needs with physical health needs. Patients and providers also face care coordination challenges when the same people, either concurrently or over time, require care for both mild-to-moderate and more serious behavioral health conditions. Although respondents shared examples of increased integration and smoother handoffs, integration efforts remain a work in progress.

In Riverside County, RUHS Medical Center, county-run CHCs, and the county behavioral health and public health departments are all housed under the RUHS organizational umbrella, which streamlines information exchange, eases patient handoffs, and enables funding flexibility. Over the past five years, sites and services have been added or consolidated so that all 13 RUHS CHCs now have on-site mental health and SUD services, in many cases colocating county behavioral care for people with serious mental illness in the buildings that house county-run CHCs. Respondents noted that colocating behavioral health services with primary care in CHCs increases the likelihood that people will access services earlier in the disease course, potentially preventing severe declines in health status that would demand more county resources.

The San Bernardino County Department of Behavioral Health (SBDBH) provides outpatient services for people with serious mental illness and SUDs through both in-house and contracted providers. The department offers walk-in crisis centers in Victorville and Yucca Valley, crisis stabilization units in Fontana and San Bernardino, and a community-based mobile crisis response team. SBDBH in-house physicians and advanced practice providers deliver specialized behavioral health services, but patients must go elsewhere for primary care, even for services closely linked to a behavioral health diagnosis such as tests for liver enzyme levels. The lack of integration between behavioral and physical health services is an ongoing challenge because SBDBH leaders reported it is unrealistic to expect a high-need, fragile population to

navigate multiple care sites and providers. SBDBH exchanges data with IEHP and Molina via a data sharing agreement and file transfer protocol rather than through a fully functional health information exchange, although the county expects to have a health information exchange in place to meet interoperability standards by mid-2026.

Medi-Cal managed care plans and both counties reported progress in implementing CalAIM's "no wrong door" policy designed to help Medi-Cal enrollees receive mental health services immediately, regardless of whether they seek care in a primary care setting via their Medi-Cal managed care plan or through the county behavioral health system. Although they fully embrace the goal and have seen some notable successes, respondents said that lack of inpatient beds and other appropriate care settings can sometimes hamper execution. One respondent said that "constant communication" and strong partnerships between county behavioral health departments and Medi-Cal plans were essential to navigate "wobbler" cases, where responsibilities are unclear. Community-based providers noted that although they can connect people with care more quickly than in the past, Medi-Cal managed care plans may be slow to send payments for non-specialty services for patients who also have specialty behavioral health needs.

While respondents were proud of and encouraged by expanded behavioral health capacity and improved care coordination among providers and systems of care, they reported feeling overwhelmed at times by the sheer number and demands of simultaneous Medi-Cal behavioral health initiatives. "People do their best, but just too much is going on," a respondent said. "Sometimes we risk overlooking the basics as we try to meet [programmatic] criteria and reporting requirements." Although counties reported expanded behavioral health capacity and improved handoffs, organizations referring people for services reported having limited visibility into whether patients receive timely care.

Infrastructure Investments Add Behavioral Health Beds

Across the Inland Empire, inpatient and step-down bed capacity for people with SUDs and other behavioral health care needs is insufficient, according to respondents. Several reported that inadequate treatment settings for patients with behavioral health needs contribute to long ED wait times and hospital lengths of stay.

Created in 2021, BHCIP authorized DHCS to award local grants to support behavioral health infrastructure investments. The original authorization resulted in $1.8 billion in awards over five rounds of BHCIP funding. Two major RUHS initiatives received BHCIP funding:

- The $185 million RUHS Behavioral Health Wellness Center in Moreno Valley will serve as Riverside County's inpatient acute psychiatric facility, adding a 100-bed unit with 76 adult beds, 12 adolescent beds, and 12 pediatric beds. Scheduled to open in 2029, the facility will provide high-acuity stabilization with the goal of transitioning patients to the least restrictive and most appropriate level of care once stabilized.

- Approved by the Riverside County Board of Supervisors in 2024, the RUHS Wellness Village in Mead Valley will integrate behavioral health treatment with medical care and social services on a 19.4-acre behavioral health campus. Supportive housing and children's behavioral health urgent care will also be offered.[66] The hope is to create "a place where individuals of all ages can access a range of services in an environment designed to foster healing, community interaction and overall wellbeing."[67] The facility is slated to open in 2027 and will offer expanded step-down options to support people's reintegration into the community following stabilization of serious mental health or SUD conditions. The Mead Valley Wellness Village received $80.4 million from BHCIP,[68] and the balance of the $580 million project was financed through a public-private partnership.

Additional BHCIP grants to Inland Empire organizations included the following:

- Harmony Haven Children and Youth Wellness Center, Beaumont, Riverside County, received $150 million to establish a 30-bed adolescent residential SUD facility, a 16-bed psychiatric residential treatment facility, and urgent care and outpatient behavioral health and substance use services on a campus with an emergency transitional shelter for displaced youth.
- Pacific Village Platinum Campus, San Bernardino, received $39 million to fund a 32-bed SUD facility on a campus with permanent supportive housing and recuperative care units funded by a mix of federal, state, and local funds.[69]
- Cedar House Life Change Center, Bloomington, San Bernardino County, received $30 million to add 70 beds to an existing residential SUD facility.[70]
- House of Hope Women's, Desert Hot Springs, Riverside County, received $5 million to add 20 SUD and behavioral health beds.

Solutions Don't Match Scale of Need

Despite widespread and diverse strategies to expand access to behavioral health care services, respondents expected ongoing challenges. Significant shortages of behavioral health care providers cannot be quickly resolved. Additionally, long travel times make it difficult for the available workforce to reach outlying rural areas. While respondents welcomed Medi-Cal payment reform for behavioral health services, they reported inadequate acknowledgment of time and travel costs to serve distant sites. The use of telehealth for behavioral services reportedly peaked during the pandemic and has since declined, with patients increasingly wanting in-person access even as providers sometimes prefer the convenience of virtual sessions. Moreover, some providers reportedly are unwilling or unable to serve people with complex or higher-acuity behavioral health care needs, contributing to uneven access. Other challenges involve funding for ongoing operations and workforce to staff the expansions underway and improving navigation and information sharing across the continuum of care for patients, families, and providers.

Federal and State Budget Headwinds Threaten Hard-Won Gains

Interviews with regional health leaders were conducted close to the time that HR 1 was signed into law on July 4, 2025, prompting widespread concern that federal policy shifts could undermine many of the Inland Empire's recent gains in health care access and affordability. Over 10 years, HR 1 will cut Medicaid spending nationally by more than $900 billion, resulting in an estimated 10.3 million people losing Medicaid coverage.[71] In California, as many as 3.4 million people may lose Medi-Cal coverage, which will in turn reduce health care access and increase household financial burdens.[72] Consistent with these national forecasts, HR 1 provisions were widely expected to adversely affect the financial stability of Inland Empire health care providers.[73] Respondents expected shifts in Medi-Cal eligibility for immigrants, new work and community engagement requirements, and more frequent eligibility redeterminations to reduce the number of Medi-Cal enrollees. Loss of Medi-Cal coverage would in turn reduce visits and payments for CHCs while increasing ED visits and uncompensated hospital care.

Also, new provider tax limitations will reduce Medi-Cal directed payments that supplement hospital payments, worsening the financial position of hospitals, particularly those serving many Medi-Cal and uninsured patients. Any relief from HR 1's $50 billion federal Rural Health Transformation program was not expected to make up for these losses. Hospitals in turn will likely bargain more aggressively for higher payments from Medi-Cal managed care, MA, and commercial health plans. Some respondents noted that California might find a

way to backfill federal funding reductions, but most believed that prospect was unlikely. HR 1 also may interfere with efforts to expand the health care workforce. Reduced federal education loan aid is likely to adversely affect health professional education in general and studying and working in the Inland Empire in particular, according to respondents.

Beyond HR 1, other federal policies threaten health care access and affordability and the financial viability of providers, particularly those reliant on public payers. The expiration of enhanced federal premium subsidies will reduce Covered California enrollment. Moreover, heightened federal immigration enforcement activity is making undocumented immigrants and their household members reluctant to engage with health care providers, negatively affecting their care. At the same time, to address a budget deficit for fiscal year 2025–26, California enacted changes to Medi-Cal coverage for undocumented immigrants, including an enrollment freeze.[74] FQHCs must serve all patients regardless of ability to pay, and these changes will bring an increase in uninsured and self-pay patients.

Looking to an Uncertain Future

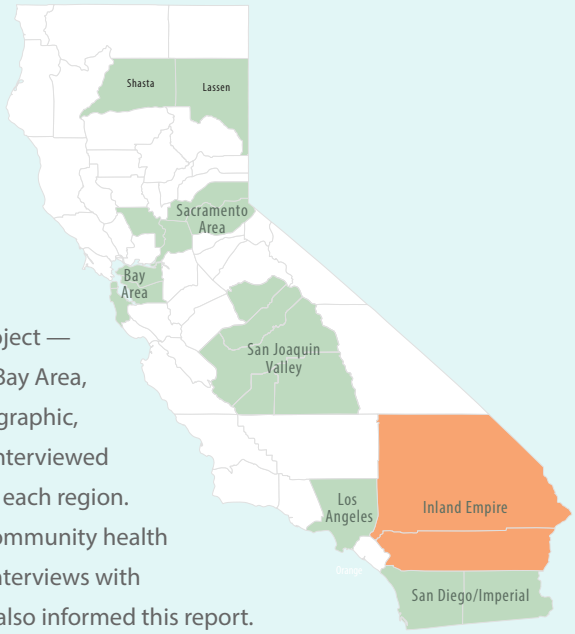
HR 1 changes and the moratorium on state-funded Medi-Cal coverage for undocumented adults age 19 and older will increase demand on medically indigent programs, straining county and health care provider budgets.[75] Currently, both Riverside and San Bernardino Counties maintain only limited benefits and services through their medically indigent programs and thus will be challenged to identify program savings with the potential to offset sizable increases in demand. In sum, respondents feared that the coming state and federal policy changes would undermine gains in health care coverage, access, and affordability and threaten the relative organizational and financial stability of most Inland Empire health care providers. However, having successfully navigated major changes and great uncertainty in the past, many regional leaders hoped to be able to do so again.

Issues to Track

- How will hospitals, particularly those already facing financial distress, respond to increasing financial pressures? Will financial challenges spur increased consolidation in the region's hospital and physician markets?
- Will a new UCR teaching hospital be built? If so, what impact will a new hospital have on payer mix and workforce needs at other Inland Empire hospitals?
- Will independent physician organizations continue to provide a viable alternative to corporate ownership, or will acquisition of medical groups accelerate? If so, how will changes affect patient care?
- How will CHCs respond to Medi-Cal cuts? Can CHCs maintain new sites and services, or will they be forced to retrench?
- Can the region's workforce gains be maintained and expanded? Can technology and other strategies expand workforce capacity, especially in remote rural areas?
- How will major behavioral health infrastructure investments affect access and outcomes? What lessons about improving care delivery will emerge?
- How will Inland Empire residents and providers fare as federal and state budget cuts and policy shifts threaten gains in access to care? Which subregions, populations, and systems of care will be most affected? How will county programs for medically indigent people respond?

BACKGROUND ON REGIONAL MARKETS STUDY

Between June and September 2025, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in Riverside and San Bernardino Counties in Southern California to study the market's local health care system. The Inland Empire is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fifth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25–30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, community health centers, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.



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ABOUT THE FOUNDATION

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

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