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UNITED STATES BANKRUPTCY COURT

SOUTHERN DISTRICT OF CALIFORNIA

In re: BORREGO COMMUNITY HEALTH FOUNDATION, Debtor and Debtor In Possession.	Case No.: 3:22-02384-LT11 Chapter 11 Case **FIRST REPORT OF PATIENT CARE OMBUDSMAN, JACOB NATHAN RUBIN, MD, FACC, PURSUANT TO 11 U.S.C. § 333(b)(2)** [No hearing set]

Jacob Nathan Rubin, MD, FAAC, the Patient Care Ombudsman ("PCO") appointed under 11 U.S.C. § 333 in the above-referenced chapter 11 bankruptcy case of Borrego Community Health Foundation ("Debtor"), hereby submits his first report ("Report") to the Court pursuant to 11 U.S.C. § 333(b) regarding the quality of patient care provided to patients of the Debtor. The Report is attached hereto as **Exhibit A**.

Dated: November 11, 2022

LEVENE, NEALE, BENDER, YOO & GOLUBCHIK L.L.P.

By: */s/ David B. Golubchik*
DAVID B. GOLUBCHIK
Attorneys for Patient Care Ombudsman

EXHIBIT A

IN RE BORREGO HEALTH SYSTEMS, INC.

FIRST REPORT OF PATIENT CARE OMBUDSMAN

PURSUANT TO 11 U.S.C. § 333

I.

PCO's APPOINTMENT AND SCOPE OF REVIEW

Borrego Community Health Foundation ("Debtor") is a health care business as defined under § 101(27)(A) of the Bankruptcy Code, 11 U.S.C. § 101, et. seq (the "Bankruptcy Code")[2]. The Court ordered the appointment of a PCO pursuant to § 333 (a)(1) to monitor, and report to the Court, the quality of patient care provided by the Debtors. The PCO, whose appointment by the U.S. Trustee was approved by the Court, performed the duties described in § 333(b) and (c). The PCO performed these duties with the assistance of a Court approved, qualified employed expert, Dr. Timothy Stacy. Additionally, the Court approved counsel to provide legal guidance to the PCO regarding the performance of his duties under the Bankruptcy Code.

This Report consists of the PCO's in-depth evaluation of each of the Debtor's health care facilities' ability to adhere to, and comply with, the applicable medical standard of patient care. Subsequent to the PCO's initial evaluation, as discussed herein, the PCO will continue to perform contemporaneous monitoring of any identified issues pertaining to a specific Debtor entity and the identified global issues requiring Debtor's immediate attention, and as required by Sections 333(b) and (c).

II.

SOCIAL DETERMINANTS OF HEALTH

Any analysis and consideration of patient care must focus not only on medical treatment of patients, but also on the Social Determinants of Health. Specifically, the World Health Organization (WHO), the Department of Health and Human Services (HHS), the Centers for

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[2] All references to "Section" or "§" are to sections of the Bankruptcy Code, unless otherwise noted.

Disease Control (CDC), and the Center for Medicare Services(CMS), have all recognized that Social Determinants of Health (SDOH) influence outcomes as much as the disease processes. Below is an excerpt from the U. S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion website (https://health.gov/healthypeople/priority-areas/social-determinants-health) with respect to SDOH:

What are social determinants of health?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH can be grouped into 5 domains:

Economic Stability
Education Access and Quality
Health Care Access and Quality
Neighborhood and Built Environment
Social and Community Context

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

The PCO's investigations during the pendency of this case has also focused on SDOH factors in connection with patient care.

III.

INTRODUCTION

The PCO's initial urgent review of the Debtor's facilities, just days after being appointed, was in response to the likely shuttering of the Debtor's FQHC clinics because of a threat by the State to cease Medi-Cal payments. As discussed in the PCO Declaration of September 27, 2022 (attached for reference hereto as **Exhibit 1**), the Debtor's patient population is underserved and many of the clinics are in remote geographic areas. The PCO found, after visiting all patient care locations, that the Debtor was meeting the standard of care in well-maintained, state of the art facilities. However, the State was shutting the Debtor down for quality of care issues. The health plans inferred from the Attorney General's and California Department of Health Care Services ("DHCS")'s comments that the patients were to be transferred from the Debtor and thus created more concern and the PCO's supplemental declaration (**Exhibit 2** hereto) was filed.

While the Court allowed the Debtor to continue to provide care, this still begged the question: did the PCO miss something Berkeley Research Group ("BRG" or the "Monitor"), the Monitor appointed by DHCS prepetition, and DHCS found to be so wrong that closure was the only remedy?

To answer this question and to further assess the quality of care, the PCO performed a more in depth review of the Debtor, examined the Debtor's measures of quality, and BRG's assessment of quality. In addition, the PCO reviewed external indicia of care: governmental agency investigations, health plan actions, malpractice claims, malpractice carrier actions, and, ultimately, patient voluntary disenrollment.

The following sources of information were considered by the PCO as part of his investigatory process:

1. The PCO revisited some of the clinics, urgent care facilities, and administrative offices. The PCO conducted a more in depth review of the Debtor's facilities and included review of the peer review processes, referral processes, grievance processes, data collection methodology, and quality measures as reported to BRG.

2. The PCO also considered the Debtor's quality measures as reported which included Healthcare Effectiveness Data and Information Set ("HEDIS") reporting, methodology of the Debtor's data gathering process, metrics, validity of the measurements, analysis, and conclusions.
3. The Monitors were interviewed, and the quality of care reports were analyzed.
4. The PCO analyzed government agency reviews, including those from CMS and CDPH.
5. The PCO analyzed health plan reviews and actions against the Debtor (if any), a subcontractor, and overall ranking of Inland Empire Health Plan ("IEHP") as the Medi-Cal contractor.
6. The PCO also reviewed any malpractice claims and settlements of litigation going back more than 6 years.
7. The PCO also reviewed voluntary patient disenrollment.

Further, the PCO considered the effect of the Debtor being forced to close, and the patient safety concerns and possible options and mechanisms. The PCO will discuss possible consequences and obligations associated with such possible closing.

Ultimately, as discussed in detail in this Report, the PCO concludes that the Debtor meets the standard of care and should remain open.

IV.

DEBTOR'S QUALITY OF CARE BY SOURCE OF INFORMATION

1. PCO in depth, in person, revisit of the Debtor.

The PCO visited each of the Debtor's facilities to personally review operations, patient throughput, Electronic Medical Records ("EMR") processes, and speak with the managers, healthcare providers, and patients about their perception of care delivery. The PCO performed a comprehensive review of onsite systems, direct observation of patient care, evaluation of the EMR system and review of real-time healthcare data at the Debtor's facilities.

A. FACILITIES

The providers and directors that work at the Debtor's facilities have a comprehensive understanding of Debtor's facilities operations that include potential biases that skew reported data.

Therefore, the PCO and his consultant went to each facility and spoke to the individuals that provide care. Visiting the clinics afforded the PCO the opportunity to experience the care delivered to the patients in real time.

In preparation for patient appointments, the team performs a "pre-visit huddle" on each patient scheduled to be seen to address the health maintenance prompts provided by the EMR system.

B. EMR

The PCO spent several hours with the EMR developer who reviewed the EMR system and how providers negotiate each visit. The EMR system is robust and provides the clinician with valuable health maintenance records, preventative medicine alerts, and allows the provider to document and order tests and referrals with efficiency. Much of the health quality data is collected via the EMR system.

Based on the PCO's investigation, the EMR and Debtor are HIPPA compliant.

C. Facilities Visited.

1. Anza Community Health Center, Borrego Medical Clinic Borrego Springs and Borrego Pharmacy Borrego Springs

The Anza clinic is a remote rural clinic that was visited in person and is well equipped. A tour of the facility and discussions with managers was performed.

The PCO found a central theme in these remote clinics: no other facilities or providers are available to care for them.

The Borrego Springs clinic and pharmacy is remote and contains state of the art equipment. In addition to visiting the clinic, the PCO toured the city and surrounding area to investigate local access to care. Very few independent medical providers are available in the area. Those that are available do not accept Medi-Cal patients.

In addition to the paucity of available medical providers to the community, pharmacy providers are likewise limited.

Borrego Springs provides medications to the underserved community that Borrego Springs

clinic serves through the 340-B[3] program. The PCO spoke to the pharmacy director who confirmed that without the 340-B pharmacy, most of the patients would not be able to obtain lifesaving medications.

The Borrego Springs clinic is so remote that it sits on the same property, adjacent to a Mercy Air Medical Helicopter center. The nearest hospitals are greater than 40 miles away and more than an hour drive.

In both the Anza and Borrego Springs clinics, the providers and pharmacy staff are part of the community. They perform services such as fill prescription boxes, visit, and interact with patients in the community outside of business hours. The providers and staff are familiar with not just patients and immediate families, but multiple generations of those families.

2. Centro Medico Cathedral City

This clinic and urgent care center were visited on two separate occasions by the PCO. The urgent care is busy since it also provides care for patients that need to be seen sooner than the primary care provider is available.

3. Centro Medico Coachella and Coachella Valley Community Health

Coachella Valley Community Valley Health Center is a brand-new state of the art multispecialty clinic that provides care to a large vulnerable population. The PCO visited the clinic twice. The PCO spoke with the managers of the clinic, the physicians, and the other providers about the operations.

4. Central Medico El Cajon and Central Medico Escondido

These remote clinics in San Diego were visited via zoom. The visit consisted of a tour of the facility and an interview about operations of the facilities. There was a discussion regarding the population served and the impact of the clinics to the patients served. Again, these are clinics that serve a large vulnerable population that are supported by 340B pharmacies to obtain treatment and medication otherwise financially unobtainable.

[3] The federal 340B Drug Pricing Program allows qualifying hospitals and clinics that treat low-income and uninsured patients to buy outpatient prescription drugs at a discount of 25 percent to 50 percent. The program is intended to help safety-net health care providers stretch their financial resources to reach more financially vulnerable patients and deliver comprehensive services.

5. Central Medico Oasis Thermal and College of the Desert Palm Springs

The PCO personally visited these clinics that primarily serve and provide Family Medicine, Women's Health, and Pediatric care. During the visit to these clinics, the PCO learned that the patients were calling in concerned that they were receiving new insurance cards with new providers and hospitals that were up to up to a two-hour drive depending on weather. Some of these patients were in the second and third trimester of pregnancy.

The clinic provided the PCO copies of the insurance cards that the patients received that showed that their healthcare and maternal care was diverted to Lake Arrowhead hospital. This is a hospital that is in the mountains with roads that are closed several days in the winter months. Obviously, the patients were stressed by their inability to acquire both transportation and time off work.

This issue was addressed in the supplemental declaration to the court. This problem has reportedly been resolved.

6. Desert Hot Springs Main campus, Desert Hot Springs Specialty clinic, Desert Hot Springs Health, and Wellness Center, Martha's Village Clinic Indio, Palm Springs Family Health

These centers were also personally toured and visited by the PCO. These clinics provide primary care, women's health, and dental care. No problems were identified.

7. Mobile Clinics

The mobile clinics were visited by the PCO. These mobile clinics are new retrofitted recreational vehicles that travel to provide health care to rural areas. These mobile clinics provide vaccinations and healthcare to students at local and rural schools.

The PCO learned that the mobile clinics also provide care to migrant farm workers. The farm owners allow the mobile clinics to park on the fields so that the migrant workers can obtain healthcare during their breaks.

Without these mobile clinics, the migrant workers would not be able to obtain care as they must work to provide for their families.

8. Stonewall Medical Center and Stonewall Pharmacy[4]

The PCO visited the Stonewall clinic on two separate occasions because of the of the specific care delivered to the HIV, Mental Health, Transgender and LGBTQIA+ community. The PCO met with the medical director, Dr. Barbour, on both occasions to discuss the ongoing need for continuity of care.

As already described in the PCO's declarations to the court, it must be reemphasized that these vulnerable patients are established at this specific clinic and require continuity of care to remain in good health. The onsite 340B pharmacy provides the medications for most of the Debtor's clinics. The medication that these patients require are expensive, and frequently will not be obtainable without the 340B pharmacy program.

Displacing or interrupting the care of these patients will result in irreversible harm to the patients mental and physical well-being.

D. Subsection Conclusion of the PCO's Facilities' Review

The facilities are well kept with the latest medical equipment available in each. Experiencing the daily facility operations firsthand was enlightening. The Debtor is meeting the standard of care.

2. **The Debtor's Quality Measures.**

The quality measures data as submitted by the Debtor to BRG and then to DHCS was reviewed by the PCO and was inconsistent with the onsite evaluation of the clinics. The PCO did not find the quality of care to be substandard. To understand the discrepancy between what the PCO observed at the facilities and the data presented to DHCS via BRG, the decision was made to critically review the data and reports.

To evaluate the data the PCO investigated the following questions:

1. How was the data collected?
2. Who was reporting the data?

[4] All of debtor's facilities are eponymous with their location but for Stonewall. The Stonewall facilities are named in honor of the watershed event that started the LGBT movement and gay liberation. All major Pride events commemorate and occur on the anniversary of the June 28, 1969, Greenwich Village Stonewall Inn riots. The cultural, social, and historic significance of Stonewall was not lost on the Debtor, the patients or the staff.

3. Was there a critical review and analysis of the data by qualified personnel to adjust for confounding errors before submitting the data to the monitors?

4. Was the collection methodology of the data accurate?

The PCO learned that quality data was collected and reported by the quality manager employed by the Debtor. The PCO attempted to interview the quality manager that submitted the quality data reports to BRG and learned that she had resigned.

It was discovered that the collection of the data was not reviewed or adjusted for errors by the Quality Manager. Critical review and analyses were not performed by the Quality Manager. The data was submitted to BRG without approval or review by the board of the Debtor, the CEO, the CFO or the CMO. The data was then transmitted unfiltered to BRG and then sent to DHCS, as reported in the Busby Declaration. [Adv. Pro. Docket No. 31]

A. Busby Declaration.

The Busby Declaration cites "Borrego Corrective Action Report (Quality Monitoring)" from the Independent Compliance Monitor Report of September 23, 2022, which is then used to demonstrate substandard care.

From the outset, it should be understood that the "measures" are self-reported, aspirational goals of an organization, and facilities are not closed for unmet goals. Examples from the report.

1. PCP visit within 7 days of hospitalization was 55% complaint with goal of 58%. According to the CEO of Desert Regional, Debtor sees 100% of Desert Regional's unfunded patients within 7 days of hospital discharge. The problem facing the Debtor is that it is not automatically made aware of its patients being discharged from hospitals. It is the discharging hospital or the patients' responsibility to make an appointment.

2. Controlled Blood Pressure. 59% compliance with goal of 70%. All patients have their blood pressure checked and treated. The patient must comply with treatment plans and comply with dietary regimens and take their medications as prescribed. This is not controlled by the Debtor.

3. Colorectal Cancer Screening. 40% compliance with 70% goal. Here too, the patients must follow through with the exam.

4. Referrals. Only 33% compliance. This is in fact a problem. The Debtor referral team is working at half-staff due to funding and Covid related retirements. Getting referrals approved by the health plans requires rigorous documentation and transmission of data.

Based on the PCO's research, the PCO believes that the Debtor cares for vulnerable populations with limited financial resources which prevents them from taking time away from work to perform preventative health screenings such as colonoscopies and mammograms. Health plans are graded on preventive medicine screenings despite the fact that patients are not able to comply due to financial or travel logistics. Patients will most often choose to work rather than lose several days of work for various medical screening tests. Similarly, patients with limited financial resources tend to purchase less expensive food such as fast food that is high in fat and cholesterol. The food choices that patients make because of financial restraints relate to higher cholesterol levels, high blood pressure and out of control diabetes. According to the monitoring guidelines set by NCQA, the health plans are graded irrespective of social disparities that determine patient health behaviors. The social determinants of health care have not been considered.

B. Centro Medico Cathedral City Referral Center

The PCO reviewed the referral data provided by BRG and wanted to better understand the referral process. The PCO followed and tracked the referral process from the point when the provider placed the referral in the EMR system to the referral center. A visit to the referral center and interview with the director helped the PCO understand the process at the ground level.

The provider enters the referral at the time of the visit. The referral is immediately transmitted to the referral center for processing. The referral processing at the main center was explained to the PCO in detail and demonstrated in real-time.

Processing of the referrals is cumbersome and require the referral center to send the referral to the health plans for authorization that may take several days to complete. This process requires the employees to open several different health plan portals to enter the demographics, send the patient's record and then await authorization to provide the patient with the approval.

Upon approval of the referral, the patient must be able to make an appointment with the specialist that may be many miles away from the originating clinic. If the health plan denies the referral, the patient must return to the provider who sent the referral to establish next steps to provide care.

The PCO found that the referral department has eight open positions that are not being filled because of the financial issues that forced the bankruptcy filing.

In summary, as part of the PCO evaluation, the data provided to BRG regarding referrals was evaluated at ground level with first person review of the processes. The referral system of the Debtor and the health plan, both for routine and stat referrals is burdensome and requires systems outside the control of Debtor. The system is inefficient and labor intensive.

Despite the lack of employees, and the Debtor's dependency on the health plans to provide efficient feedback, the referral center is working diligently to meet goals.

C. Subsection Conclusion

The PCO does not consider any of the Debtor's self-reported submitted quality measures, whether good or bad, to be a reliable indicator of Quality of Care. However, the Debtor continues to monitor and pursue these aspirational goals. The Debtor is working diligently to speed the referral process.

3. **BRG Methodology and Conclusions: an inquiry into BRG to understand BRG's findings.**

BRG acknowledged and reported that the quality data received from Debtor lacked accuracy. Good or bad, the data was accepted as presented, despite being self-reported.

The following questions were then asked:

1. BRG's mission at Borrego?

2. The standards BRG was applying to assess quality of care, ie, whose standards are being applied?

3. The CV's of the reviewers of health care, ie, their credentials?

4. The methodology applied, eg, surveys, in person interviews, and with whom? Was there chart review? How many interviews or charts reviewed? How was sample size determined?

Which sites were visited?

5. The reports BRG generated and corrective actions suggestions, were requested.

6. The timing of follow up and the methodology for the assessment of Debtor's compliance?

In short, the Monitor is a well-qualified nurse who is well versed and trained in CMS guidelines. It appears that the intended standards being applied were those applicable to hospitals, and not ambulatory care centers. However, no real standards were actually applied! The "independent" Monitors reported that they had never been to any of the Debtor's facilities. BRG simply took the Debtor's reports and "copied and pasted them". BRG further reports that BRG drew no conclusions of their own. All conclusion by DHCS belong to DHCS and should not be attributed to BRG and the "independent" Monitors.

A. "Independent" Monitor Concerns

During our interview with the Monitors, the Monitor went into detail about "quality of care" issues such as grievances, dropped calls, third next available appointment time and referral delays.

1. Grievances.

There were a multitude of customer service grievances, but they occur in less than 1:1000 patient interactions, although this is probably an underestimation, and again, related to staffing.

2. Dropped calls.

This happens after a long wait time on hold. The PCO called the clinic and verified that the message starts with: "If this is an emergency, call 911", as expected.

3. Third next available appointment.

The staff was confused when they were told about third next available appointment, and as a result, were giving patients the third next available appointment rather than the next available appointment.

4. Referral Delays.

This remains a problem as described previously in this report.

Bias

When looking at reports or studies and their conclusions, bias must be evaluated. It appears that BRG is biased toward finding fault with the Debtor. The data presented to BRG was considered to

demonstrate poor quality of care and was not analyzed in any fashion. If the self-reported data was good, would that have been the case? Would that data have been sent along unrefuted or unaltered? DHCS, via BRG's monitoring, has sought to close the facilities based on customer service issues and not true health care issues.

BRG, by BRG's report, is under control and reports only to DHCS. As a result, PCO believes that BRG is not an independent monitor.

C. Subsection Conclusion

Potential bias aside, the PCO can draw no conclusions from BRG's monitoring. BRG, by its own admission, has also drawn no conclusions. The PCO does not consider the Quality of Care issues as reported by the monitors, to be substandard, but rather, customer service issues that are being addressed by the Debtor.

The delay in referrals is a problem, as already reported, and, again, the Debtor is working on hiring referral coordinators.

4. **Governmental Agency Reviews**

The PCO requested all CDPH and CMS driven investigation documentation.

CDPH investigates complaints that concern public health. A CDPH investigation can be initiated by patients, patients' families, providers, employees, or any party that observes potential wrongdoing. Upon a complaint, CDPH sends investigators to the facility without warning to address any complaints regardless of validity. The PCO confirmed that CDPH did not receive any complaints or initiate any investigations at any of the Debtor's facilities.

In addition to CDPH, CMS also performs investigations of complaints related to Medicare recipients. The PCO learned that no CMS investigations were conducted at the Debtor's facilities.

Subsection Conclusion

The PCO was surprised that no CDPH or CMS investigations were filed or conducted after reading DHCS complaints.

5. **Health Plan Actions and Ranking**

National Committee for Quality Assurance (NCQA) is a non-profit organization that is charged with reporting and comparing health plans quality, specifically managed care plans. In

addition to the reporting quality, the organization provides accreditation to health plans. NCQA monitors health plans by measuring quality improvement and measurement goals reported as Healthcare Effectiveness Data and Information Set (HEDIS).

IEHP provides care to Medicaid patients and is accredited by NCQA. IEHP is required to report HEDIS data to NCQA. The rating of the health plan is public and found on the NCQA website. IEHP, among the health plans that report data, is above average in NCQA ratings in California.

NCQA goals are aspirational and assist health plans in developing processes to address important health maintenance goals. Unfortunately, the health plans are graded on goals that are, at times, out of their control and related to the patients' socioeconomic restrictions. As already noted, according to the monitoring guidelines set by NCQA, the health plans are graded irrespective of social disparities that determine patient health behaviors. The social determinants of health have not been considered.

Debtor is a sub-contracted provider for IEHP. No reported actions were taken by IEHP against the Debtor

Subsection Conclusion

The PCO reviewed the data reported and the rating of IEHP. In California, IEHP is rated seventh of the 16 health plans that are reporting data. Nine other California health plans are rated below IEHP, yet remain open and are not under investigation or threat of revocation of state funds.

6. **Malpractice Cases**

The PCO reviewed medical malpractice lawsuits occurring over an approximate 6-year period which would have come from nearly two and half million visits. The lawsuits that resulted in large settlements or awards due to catastrophic outcomes while in the labor and delivery units of the hospital were not related to treatment at the Debtor's facilities.

A single outpatient lawsuit that resulted in settlement to the patient was related to a missed diagnosis in the clinic that resulted in permanent hearing impairment. This single lawsuit was the only significant malpractice settlement that emanated from the clinic in a six-year period that covered nearly 2.5 million outpatient visits.

Additionally, as part of this analysis, the PCO evaluated the data to look for event clusters: patterns of missed diagnoses or inappropriate treatment. The PCO did not find any event clusters.

Subsection Conclusion

Malpractice lawsuits are neither more frequent, nor more severe, than would be expected. The labor and delivery lawsuits occurred in the inpatient setting which are out of control of the Debtor.

7. **Malpractice Carrier Issues.**

The federal government is the malpractice carrier for FQHC's. Had there been a high rate of lawsuits or settlements, the federal government, would have made significant inquiries into the practices of Debtor.

8. **Patient Voluntary Disenrollment.**

None found or reported. However, the patients' options are limited and this may be an underrepresentation as reported.

V.

SECTION CONCLUSION

RE: STANDARD OF CARE WHEN ALL SOURCES OF INFORMATION ARE CONSIDERED.

CDPH, CMS, IEHP, plaintiffs' lawyers, and the malpractice carrier are external to the Debtor and have remained on the sidelines.

There is a strong inference that the standard of care was met.

From direct personal observation, data review, interviews, and the above sources of information, it is the PCO conclusion that the Debtor is meeting the standard of care.

VI.

CLOSURE OF THE DEBTOR

A. Effects on the patients, the communities served by the Debtor, and the Debtor's employees should the Debtor be closed.

This was already discussed in the PCO Declaration and Supplemental Declaration, and will not be revisited here. Note however, that once the providers and staff leave the remote communities, as a result of their unemployment, reconstituting the FQHC's will be improbable.

The PCO's has experience with previous closures in Verity, a 501(C)(3), healthcare bankruptcy with multiple closures as follows:

1. The closure of the Oncology clinic at Seton Hospital. Every patient was transferred to Stanford with a confirmed follow up appointment.
2. The closure of the Highland Park Clinic. Every patient was transferred to another nearby clinic with a confirmed follow up appointment.
3. The closure of the Kidney Transplant Unit. Every patient was transferred to a nearby hospital with a confirmed follow up appointment with the same transplant surgeon.
4. The closure of the Liver Transplant Service. Verity created a team to guarantee that every patient was transferred to an approved transplant center with timely appointments and transportation.
5. The expected closure of Dr Keely's office. Dr Keely had 5,000 patients. It was considered impossible to move 5,000 patients to other providers. Ultimately the Debtor extended her lease, Dr. Keely joined another health plan, and the patients' care was uninterrupted as the practice was not moved to another location.

The Court, the Debtor, and the PCO worked together to assure a safe landing for every patient.

B. Consequences And Obligations Associated With The Closure Of The Debtor And The 340-B Pharmacy

The application of the precedent described above is clear. It is the responsibility of all concerned to assure the health, safety, and continuity of care of the patients if the Debtor is closed. It must be recalled that the 340B Pharmacy provides medications to all the Debtor's patients based on ability to pay, and this needs to be replaced to assure treatment of ongoing chronic illnesses. It must also be recalled that access to care is maintained by having transportation in place at the time appointments are scheduled, and meet the time and distance standards applied to FQHC patients.

The social determinants of health cannot be ignored.

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VII.

CONCLUSION

1. All sources of information, including direct personal observation by the PCO, confirm that the Debtor is meeting the standard of care.

2. The Debtor has customer service issues but no significant Quality of Care issues.

3. The Debtor is diligently working on improving its processes.

4. The Debtor and the Debtor's patients would benefit from the Debtor's ability to fully staff their call centers and referral centers. This is an economic issue beyond the scope of the PCO.

5. If the Debtor is forced to close, the effect on the patients, their families, and the local community, has the potential of causing irreparable and avoidable harm. As a result, the social determinants of health will be adversely impacted.

6. If the Debtor is forced to close, it is the responsibility of all concerned to offer all patients a safe landing with accessible, affordable care, and medication, as envisioned by the Affordable Care Act.

7. The patients, the providers, the Debtor's staff, and the local communities should not be punished for the wrongs of those previously in control of the Debtor's finances.

Dated: November 11, 2022

JACOB NATHAN RUBIN, MD, FAAC,
Patient Care Ombudsman

By: _____
JACOB NATHAN RUBIN, MD, FAAC

EXHIBIT “1”

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA

In re BORREGO COMMUNITY HEALTH FOUNDATION, a California nonprofit public benefit corporation, Debtor and Debtor in Possession.	Case No. 22-02384-11 Chapter 11 Case
BORREGO COMMUNITY HEALTH FOUNDATION, a California nonprofit public benefit corporation, Plaintiff, v. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Defendant.	Adv. Pro. No. 22-90056 **DECLARATION OF JACOB NATHAN RUBIN, PATIENT CARE OMBUDSMAN, IN SUPPORT OF EMERGENCY MOTION: (I) TO ENFORCE THE AUTOMATIC STAY PURSUANT TO 11 U.S.C. § 362; OR, ALTERNATIVELY (II) FOR TEMPORARY RESTRAINING ORDER**

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DECLARATION OF DOCTOR JACOB NATHAN RUBIN

I, Jacob Nathan Rubin, hereby state and declare as follows:

1. I am the Patient Care Ombudsman ("PCO") in the above-captioned case (the "Case"), appointed by the Office of the United States Trustee on September 16, 2022.

2. I am a medical doctor licensed by the State of California. I currently serve as the Chief of Staff at both Sherman Oaks Hospital and Encino Hospital Medical Center. I have substantial experience as a licensed medical doctor and in hospital operations and management spanning 30 years. Attached hereto as **Exhibit A** is my Curriculum Vitae.

3. I previously served as a patient care ombudsman in multiple cases, including most recently in the jointly administered cases of *In re Verity Health System of California, Inc*. et. al, (lead case number 2:18-bk-20151-ER, Bankr. C.D. Cal.).

4. I am providing this declaration to apprise the Court of certain facts relevant to the Debtor's pending *Emergency Motion: (I) To Enforce The Automatic Stay Pursuant To 11 U.S.C. § 362; Or, Alternatively (II) For Temporary Restraining Order* (the "Motion").

INTRODUCTION

5. In my role as PCO, I am required to, among other things, monitor the quality of patient care and to represent the interests of patients in the Case. For the reasons stated in this Declaration, I have concluded that closure of the Debtor's clinics would be adverse to the interests of the thousands of patients treated by the Debtor's clinics.

6. Since my appointment, I have met with the Debtor's Chief Executive Officer and other officers, the Debtor's professionals, reviewed the Debtor's bankruptcy filings, and reviewed additional historical and statistical references accessible to the PCO, including, without limitation, the Healthcare Almanac focusing on the Inland Empire, a copy of which is attached hereto as **Exhibit B**. This Declaration, including my views, expert opinion and conclusions, are based on the foregoing and my professional experience in the medical industry.

7. The Bankruptcy Code provisions establishing the role of Patient Care Ombudsman were enacted as a response to the outrage that followed from a Southern California Nursing home

having abandoned its patients to its parking lot. I believe the question before the Court now is whether forcing the Debtor to close will create avoidable harm to the Debtor's patients? I strongly believe the answer is "yes."

BACKGROUND

8, The Debtor is comprised of 4 urgent care centers, approximately 14 free standing clinics, 6 mobile clinics, and 2 pharmacies. Patient transportation to and from these various clinics is offered by the Debtor. Each is a Federally Qualified Health Center ("FQHC") as defined by the Social Security Act. In 2021, the Debtor provided care for nearly 100,000 patients with nearly 400,000 patient visits.

9. The majority of the facilities serving the Debtor's patients are located significant distances from large cities where a higher concentration of providers exists. The Debtor's FQHC's are in remote, sparsely populated areas and/or underserved areas. Less than 5% of the Debtor's patients live within one-half mile from public transportation.

10. The Debtor's 100,000 patients live in these remote areas and lack the financial, social, or logistic capacity to obtain acute or preventive care from any providers elsewhere. This is a safety net program that provides for the economically disadvantaged or those remotely located.

11. Furthermore, FQHC's are reimbursed at much higher rates(2-3x) than non-FQHC's. As a result, non-FQHC providers, in the area do not accept Medi-Cal's lower rates and the patients have no other choice for local health care.

FEDERALLY QUALIFIED HEALTH CENTERS

12. The Social Security Act expanded FQHC coverage to include medical and dental clinics, pharmacies, community health centers, public housing centers, Indian Health Services, migrant, indigent and homeless health service benefits. The Affordable Care Act ("ACA"), in recognition of the needs of the underserved, expanded the FQHC program to serve the needs of those who would become insured. An articulated goal of the FQHC's was to unburden the demand on services required from already overburdened emergency rooms (ER). By design, the patients served are typically earning within 200% of the poverty line.

13. Establishing an FQHC from inception through the establishment of reimbursement

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rates is a process that take two to three years. A clinic must be set up and staffed. A nonprofit must be established. A board must be put in place and function for 6 months. Then, State and Federal agencies must review and approve the new FQHC. One year's expenses must then be submitted for review. Only then will reimbursement be at higher rates than standard Medi-Cal rates.

THE DEBTOR'S FQHC SERVICE LINES

14. The Debtor's primary services include: General Medicine; Internal Medicine; Women's Health; Pediatric Services; Dental Services; Veteran's Health; Access Clinic; Behavioral Health; and Transgender Health.

15. The Debtor's specialty services include: Chiropractic; Hepatitis B & C; HIV & AIDS; PrEP & PEP; and Transgender Pediatrics.

16. The Debtor's ancillary services include: Digital Radiology; Mammogram Clinics; Telemedicine; Home Healthcare Services; Lab Services; and Pharmacy.

17. The Debtor's preventative services include: Cancer Screening; Well Child Exams; Immunizations; Perinatal Services; Family Planning; and Physicals.

18. The Debtor's enabling services include: Transportation Services; Translation Services; Application Assistance; Referral Coordination; Social Services; and Health Education.

THE DEBTOR'S PATIENTS

19. The Debtor's patients lack the financial, social, or logistic capacity to obtain care without the assistance of the Debtor's FQHC's.

20. The patients that are served by the Debtor are 76% Medi-Cal, 8% uninsured(unfunded), and 16% have either commercial insurance or Medicare.

21. Most of the Debtor's patients are Hispanic with a majority living within 200% of the poverty line, and again, only 5% live within half a mile of public transportation.

22. Many patients are very near the Debtor's clinics or require the Debtor's transportation to get to their appointments. Without nearby clinics or transportation, care would not be obtained. For example, in a multigenerational household (grandparent, adult child, and grandchild) if the grandparent requires transport to a clinic by the adult child who must take a day off of work, the family must decide between putting food on the table or keeping the appointment. The choice is

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clear: the appointment will be missed, and the patient will suffer. The safety net is gone. Eventually the patient gets worse and will need ER services and costly hospitalization. Multiply this scenario by thousands of lives. The Debtor's FQHC's save lives and costs.

23. Unlike Los Angeles County where most patients are relatively close to available FQHC clinics, the Debtor's patients live in areas of the Inland Empire, Palm Desert, Indio, Thermal and other remote areas, spread over many thousands of square miles, that result in low probability of patients obtaining care elsewhere because of the logistics of traveling long distances for clinic visits.

24. The Debtor informed me that dental services in the surrounding area are unobtainable but for the Debtor's dental services. It is important to note that the dental care the Debtor's patients are receiving is not cosmetic, but rather is to ensure functional and preventive care. Patients with compromised teeth and gum disease are at risk for heart valve disease, coronary disease, and digestive problems. Early treatment and management of these oral diseases prevents potentially serious medical problems that compromise the health and quality of life of these patients.

25. Without the Debtor, the only alternative for these patients is the utilization of the emergency departments of local hospitals. This will overwhelm the various community hospital emergency departments and severely stress the system, placing the entire community's public health at immediate jeopardy.

26. Emergency department saturation has been well studied and must be avoided. One of the FQHC program's originally stated goals was to decrease emergency department saturation to minimize the negative impact on community public health from overburdened emergency rooms.

ENORMITY OF THE SERVICES PROVIDED AND IMPACT TO THE COMMUNITY

27. The Debtor provides multidisciplinary care to over 100,000 patients with nearly 400,000 visits per year. Based on the data available to me and the number of patients the Debtor serves, it is guaranteed that without the Debtor, access to care will be severely limited. A large number of patients will incur debility, deterioration in quality of life, worsening of otherwise controlled comorbid conditions and death without access to the Debtor's services.

28. The unique geographic area served by the Debtor does not provide any alternatives

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for care with the exception of community hospital emergency departments. There are an inadequate number of alternative providers given the shortage of primary care providers and specialists in these underserved areas. Also, the loss of continuity of care will cause increased morbidity and mortality as established by multiple studies published by The Institute of Medicine.

29. In addition to the clinics closing, pharmaceuticals will become unavailable for the Debtor's patients. The Debtor's 340-B pharmacies provide critical medication (such as insulin) to these patients at affordable prices. Local commercial pharmacies will not be able to provide reduced prices (and often free) critical medicines needed to prevent morbidity and possible mortality

30. Many private practice providers are going out of business. The limited availability of medical providers in the country is at epidemic proportions. Practices that remain have wait times of months for patients to be seen.

THE DEBTOR'S SPECIALTY CARE

31. **LGBTQIA.** LGBTQIA patients are often marginalized individuals that are subject to social and institutional inequalities and are often denied care by providers. Providers willing to care for these patients need cultural competency and numerous hours of continuing medical education to be qualified to care and treat these patients. The need for rare and available healthcare for these patients is critical to the health and health and safety of LGBTQIA persons. The care required for LGBTQIA patients includes a multidisciplinary approach. Examples of services needed to successfully care for these patients includes behavioral and mental health, endocrinology to provide hormone therapy, gender reassignment specialists, disease prevention education and social services. Pre-exposure prophylaxis medication and counseling to prevent the spread of HIV is paramount.

32. The Debtor has a LGBTQIA specialty clinic that follows these patients in their catchment area. The Debtor is managing gender-affirming stages that require close relationships with the multidisciplinary team. Altering or transitioning these patients will induce transfer trauma that may have lifelong consequences. The care is specialized, nuanced, and cannot be easily reproduced.

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33. **BEHAVIORAL HEALTH**. Behavioral and Mental Health care is a significant problem in the nation. Finding an affordable mental health professional is extremely difficult. It is imperative that patients establish and maintain continuity of care. The Debtor manages behavior and mental health care for many of these patients that now have established relationships with their providers. Any abrupt change in therapy and medication management can cause significant personal and family trauma that may lead to the need for hospitalization or at the worst violence acted upon the families or community.

34. **MATERNAL CARE**. The Debtor partners with local hospitals to assist in the later stages of pregnancy up to delivery. Regular obstetric care delivered by the Debtor prevents untoward outcomes in Women's Health. Without the Debtor's care, or as a result of poor access to care, high risk pregnancy care will be interrupted, resulting in maternal and infant outcomes being jeopardized. Poor outcomes in the delivery room result in expensive lifelong care, a burden usually borne by the State.

35. **PREVENTION.** Prevention of most diseases is cost effective and reduces human suffering. For example, early detection of cancer helps prevent catastrophic outcomes. Treating a patient with early cervical or ovarian cancer costs much less than treating advanced metastatic cancer requiring chemotherapy, surgical oncology, and minimizes debility. The access to care provided uniquely by the Debtor allows for prevention of many costly and possibly fatal outcomes.

ALTERNATIVES IF THE DEBTOR IS FORCED TO CLOSE

36. There is inadequate local capacity for clinics to absorb the enormous number of patients currently cared for by the Debtor. FQHC's were established for exactly this patient population. These are safety net clinics.

37. The health care choice for these patients then becomes hospital emergency rooms. FQHC's were established to avoid this outcome. Causing the Debtor to close will create the problem FQHC's were designed to prevent: overburdened ER's and hospitals. In fact, the local hospitals have already asked the Debtor to help with their ER overflow. If the Covid Pandemic stresses the hospitals further this year, how will the patients be managed, and by whom?

38. The specialty care clinics cannot be reproduced locally. FQHC's were established to

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pay higher rates so these patients would be able to access care locally.

39. The local health care delivery system cannot tolerate the stress of eliminating the clinics where 400,000 visits per year occur.

40. As a practical matter, it is not possible to make 100,000 new patient appointments for the patients who would lose access to the Debtor if the Debtor were closed.

41. Should a closure of the Debtor come to pass, it is the ethical obligation of any regulatory body closing the the Debtor's FQHC's to secure timely healthcare for every single affected patient. These patients need continuity of accessible care to maintain their health. Who will be responsible for the increased costs resulting from a delay in care?

42. There is inadequate capacity within 2 hours drive of the Debtor's clinics to accommodate this number of patients. How will patients get to subsequent appointments if those appointments are far away, and the patients have no transportation and no funding? California taxpayers will ultimately bear the cost and moral burden of delayed care for the underserved.

CONCLUSION

43. Closing the Debtor's FQHC's removes the health care safety net and in effect, strikes down the Affordable Care Act for these 100,000 people, who have coverage, but who will have only limited access to care! The contemplated shuttering of the Debtor is not for quality of care issues, but rather economic issues (beyond the PCO's review). Closing the Debtor's clinics will devastate the patients served and overwhelm the health care delivery system of the communities in which the FQHC's are located.

44. The Affordable Care Act created insurance coverage for the uninsured. The Debtor's patients are the ACA intended beneficiaries. Federally Qualified Health Centers established access to health care for the previously uninsured. The Debtor's FQHC's provide access to otherwise inaccessible health care.

45. It is my responsibility pursuant to section 333 of the Bankruptcy Code to alert the Court about avoidable harms to patients related to the Debtor's bankruptcy. The Debtor's closure will cause grievous and avoidable harm to its 100,000 patients, exactly as envisioned by the statute.

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46. Simply because an action is legally permissible, does not make it ethical. The Debtor should not be forced to close. The State of California cannot be allowed to sacrifice even one life for the state's economic benefit.

I declare under penalty of perjury that, to the best of my knowledge and after reasonable inquiry, the foregoing is true and correct.

Executed this 26th day of September 2022, at LA, CA.

Jacob Nathan Rubin

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EXHIBIT "A"

Doctor Jacob Nathan Rubin Curriculum Vitae

CURRICULUM VITAE

I. PERSONAL INFORMATION

Name: J. Nathan Rubin, M.D., F.A.C.C.

Business Address:

Business Phone:

II. EDUCATION

Fellowship: Los Angeles County
University of Southern California
Medical Center, School of Medicine
Cardiovascular Diseases
July, 1985-June, 1988

Residency: Wadsworth Veterans Administration Hospital
Resident, Internal Medicine
July, 1983- June, 1985

Internship: Wadsworth Veterans Administration Hospital
Resident, Internal Medicine
July, 1982- June, 1983

Medical School: University of Southern California
School of Medicine, Doctor of Medicine
August, 1980- June, 1982

University of Oklahoma
School of Medicine
August, 1978-June, 1982

University: University of California, Los Angeles
A.B. magna cum laude-Economics
September, 1975-December, 1977

High School: Fairfax High School
Los Angeles, CA
Highest Honors
September, 1972-June, 1975

III. HONORS AND AWARDS

Patient Care Ombudsman
Appointed by Office of U.S. Trustee
Department of Justice
Multiple cases including Verity Healthcare Systems

Federal Aviation Administration
Aeromedical Examiner, No. 20620-9
Designated June 25, 1999

Expert Medical Reviewer
Medical Board of California
(at Board's invitation), December, 1996

Elected to Fellowship,
American College of Cardiology
August, 1991

Laverne B. Titus Young Investigators Forum
September, 1987

Phi Beta Kappa
June, 1978

Phi Gamma Mu (Social Sciences Honorary)
March, 1977

Omicron Delta Epsilon
June, 1976

Phi Eta Sigma (Freshman Honorary)
January, 1976

Honors Program, Letters and Sciences
University of California, Los Angeles
December, 1975

Dean's List, University of California
Los Angeles
September, 1975- December, 1977

Alumni Scholar, University of California
Los Angeles
March, 1975

Life Member of California Scholarship
Federation
June, 1975

IV. LICENSURE

State of California Medical License No.
DEA Registration No.
National Provider Identifier No.

V. BOARD CERTIFICATION

Diplomate, American Board of Internal Medicine
Cardiovascular Diseases-1989

Diplomate, American Board of Internal Medicine -1985

Diplomate, National Board of Medical Examiners
Part I- June, 1980 (Medical School year 2)
Part II- May, 1982(Medical School year 4)
Part III- May, 1983 (Internship)

VI. SOCIETY MEMBERSHIPS

National:

Fellow, American College of Cardiology
Member, American College of Physicians
Member, American Heart Association

Local:

California Medical Association
Los Angeles County Medical Association

VII. HOSPITAL POSITIONS AND COMMITTEES

Current:

1. Chief of Staff, Sherman Oaks Hospital (SOH)
2. Chief of Staff, Encino Hospital Medical Center (EHMC)
3. Chair of Bioethics, SOH and EHMC
4. Chair of Physician Well Being, SOH and EHMC

Previous:

1. Vice Chief of Staff, Sherman Oaks Hospital
2. Chairman, Credentials Committee, Sherman Oaks Hospital
3. Chairman, Bylaws, Sherman Oaks Hospital
4. Chairman, Peer Review, Sherman Oaks Hospital
5. Director Cath Lab/ Interventional Cardiology, Granada Hills Hospital
6. Vice Chief of Medicine, Tarzana Regional Medical Center
7. ICU Chairman and Director of Cardiology, Sherman Oaks Hospital
8. Credentials Committee Chairman, Valley Presbyterian Hospital
9. Medical Executive Committee, Valley Presbyterian Hospital
10. ICU Co-Chairman, Medical Center of North Hollywood

EXHIBIT “B”

Healthcare Almanac focusing on the Inland Empire

CALIFORNIA
Health Care Almanac

California Health Care Foundation

REGIONAL MARKETS SERIES

DECEMBER 2020

Inland Empire:
Increasing Medi-Cal Coverage Spurs Safety-Net Growth

Summary of Findings

A sprawling region of more than 27,000 square miles, the Inland Empire of Riverside and San Bernardino Counties is a study in geographic contrasts, with urban population centers in the west and rural, sparsely populated areas to the east. The region has enjoyed continued population and employment growth, although it continues to be poorer and less healthy than other parts of California. In recent years, the Affordable Care Act (ACA) has continued to play a large role in shaping the Inland Empire's health care sector, with increased Medi-Cal coverage decreasing the share of uninsured people and spurring growth of Federally Qualified Health Centers (FQHCs). Small group or solo physician practices remain common in the region; however, the landscape is shifting. Throughout the Inland Empire, provider shortages remain a pressing concern, although new medical schools may increase physician supply.[1]

The region has experienced a number of changes since the previous study, in 2015–16 (see page 21 for more information about the Regional Markets Study). Key developments include the following:

- **The number of FQHCs and patient visits continues to grow, bolstering the safety net.** As new FQHCs opened in the region, the number of FQHC patient visits more than doubled, from just under 500,000 in 2014 to more than 1.2 million in 2018. Nonetheless, the number of visits per capita in the region is still only half the statewide average.
- **Many physicians practice independently in solo or small practices.** Throughout the region, a large share of care is delivered by these physicians. However, the physician practice landscape is shifting as financial pressures, market conditions, and demographics all combine to make independent practice less attractive. Additionally, many younger physicians increasingly prefer the stability of an employment relationship and are drawn to the region's larger providers, including Kaiser, FQHCs, and larger medical groups.
- **The region's hospital market remains unconsolidated.** San Bernardino and Riverside Counties have among the lowest levels of hospital market concentration in California, although countywide measures can mask the extent of hospital concentration, as some hospitals are dominant in their local submarkets. There have been no mergers or significant changes to hospital market shares over the past several years, although several hospitals have closed pediatric units. Kaiser Permanente, with about a quarter of the regional market in terms of covered patients, operates an integrated delivery system with a health plan, hospitals, and its own network of physicians and continues to be a major player in the market.

- **Inland Empire Health Plan (IEHP), the region's largest Medi-Cal managed care plan, drives pay-for-performance (P4P) initiatives for Medi-Cal providers.** IEHP provides coverage to nearly 9 in 10 Medi-Cal enrollees in the region — equivalent to more than a quarter of the region's total population — and contracts with more than half of the region's primary care physicians and roughly 40% of specialists. The plan's dominant role in the Medi-Cal market provides significant leverage to engage hospitals and physicians in incentive programs using data to drive performance improvement.

- **Efforts are still being developed to embrace technology and data analytics to improve outcomes and lower costs.** Interoperability challenges stemming from the use of multiple electronic health record (EHR) systems, as well as staffing and financial constraints, especially among the region's many smaller practices, hinder adoption of quality improvement efforts. The relative lack of data sharing among the region's hospitals and physicians may also slow efforts to improve care and increase efficiency.

- **Much of the innovation surrounding integration of behavioral and physical health care in the region has occurred in the Medi-Cal program and among safety-net providers.** IEHP has supported several behavioral health integration efforts; many FQHCs in the region offer integrated behavioral health care; and both county departments of behavioral health are pursuing integration efforts. Nevertheless, access to behavioral health services remains an important issue in the region.

- **The region continues to struggle with recruiting primary care clinicians and specialists.** Compared with other California regions, the Inland Empire has fewer primary care and specialty physicians per person, with even greater disparities in the Inland Empire's eastern areas compared with the more densely populated communities to the west. New medical schools in the region, coupled with incentives to encourage newly minted physicians to practice in the area, may help mitigate this challenge in the future.

Market Background

The Inland Empire is a sprawling two-county region, spanning the borders of Los Angeles and Orange Counties in the west to Arizona and Nevada in the east. The region is home to more than 4.5 million people, split roughly between Riverside County in the south and San Bernardino County in the north.

Most people live in the larger cities, south of the San Bernardino Mountains and east of the Santa Ana Mountains. Farther east are the more sparsely populated mountain and high desert regions. The federal government owns 80% of the land in San Bernardino County, including Mojave National Preserve, and a substantial portion of Riverside County. Communities in the region's denser suburban core are generally higher income than the cities and towns such as Hesperia and Barstow dotting the mountains and high desert.

Before the COVID-19 pandemic, California's economic expansion was especially pronounced in the Inland Empire, where the unemployment rate fell by almost half, from 8.1% in 2014 to 4.5% in early 2020 (see Table 1, page 3). The drop in the unemployment rate coincided with the region's significant population growth. As the Los Angeles area continued to add jobs and new housing failed to keep pace, people moved to the Inland Empire. As a result, the populations of both Inland Empire counties have grown faster than the statewide average, with the region's population growing 5.5% over the past five years and 12.7% over the past decade.

The Inland Empire's Latinx population continues to grow more rapidly than that of other races/ethnicities, and Latinx residents now account for just over half the population of the two counties — a share that is more than 10 percentage

TABLE 1. Demographic Characteristics
Inland Empire vs. California, 2018

	Inland Empire	California
POPULATION STATISTICS		
Total population	4,622,361	39,557,045
Five-year population growth	5.5%	3.2%
AGE OF POPULATION, IN YEARS		
Under 18	25.7%	22.7%
18 to 64	61.2%	62.9%
65 and older	13.1%	14.3%
RACE/ETHNICITY		
Latinx	51.6%	39.3%
White, non-Latinx	31.5%	36.8%
Black, non-Latinx	7.1%	5.6%
Asian, non-Latinx	6.8%	14.7%
Other, non-Latinx	3.0%	3.6%
BIRTHPLACE		
Foreign-born	20.6%	25.5%
EDUCATION		
High school diploma or higher	83.6%	83.7%
College degree or higher	34.9%	42.2%
ECONOMIC INDICATORS		
Below 100% federal poverty level (FPL)	13.7%	12.8%
100% to 199% FPL	19.9%	17.1%
Household income $100,000+	30.5%	38.0%
Median household income	$65,512	$75,277
Unemployment rate	4.5%	4.2%
Able to afford median-priced home (2019)	44.9%	31.0%

Sources: "County Population by Characteristics: 2010–2019," Education by County, FPL by County, Income by County, US Census Bureau; "AskCHIS," UCLA Center for Health Policy Research; "Employment by Industry Data: Historical Annual Average Data" (as of August 2020), Employment Development Dept., n.d.; and "Housing Affordability Index - Traditional," California Association of Realtors. All sources accessed June 1, 2020.

points greater than the Latinx share of the statewide population. Notably, despite the large Latinx share of the immigrant population statewide, a large proportion of the Inland Empire's Latinx residents were born in the United States: 26% of California residents but only 21% of Inland Empire residents were born outside the United States.

Even as the region's population grew and the unemployment rate fell, in other respects the region's economy has lagged behind the state's economy. More Inland Empire residents live in poverty and fewer earn more than $100,000 annually compared with Californians generally. Thirty-five percent of Inland Empire residents have a college degree, compared with 42% of Californians statewide. The region is home to a relatively high number of construction, ecommerce wholesaler, and transportation jobs.[2] And per capita incomes remain less than two-thirds of the California average.

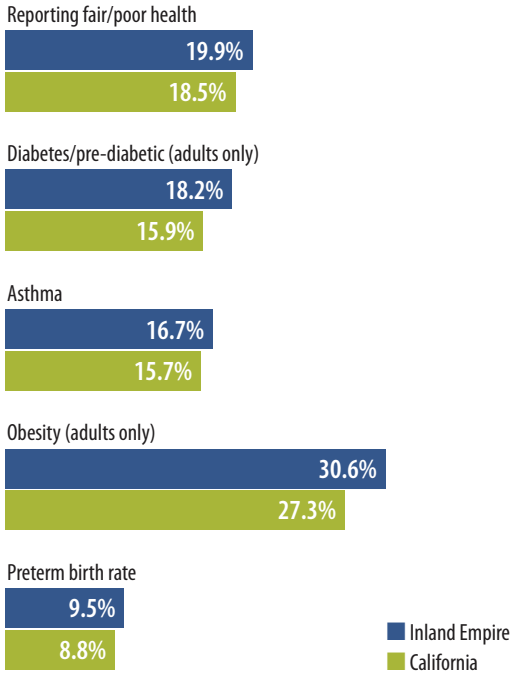
Other quality-of-life metrics also show San Bernardino and Riverside Counties trailing other California regions. The two counties have relatively high pollution levels; both rank in the bottom quartile on this metric, according to the California Healthy Persons Index.[3] To some extent, these pollution levels are the result of the region's heavy reliance on automobile travel. Many residents work outside their county of residence, and Inland Empire commute times, which average more than 30 minutes, are the longest in Southern California.[4] Relative to other counties in Southern California and the San Francisco Bay Area, there is limited access to public transit, with fewer than 5% of residents living within a half mile of a major transit stop.[5]

Inland Empire Residents Report Poorer Health Relative to Californians Generally

Across a range of both physical and behavioral health metrics, the Inland Empire's residents report poorer health relative to Californians generally. Nutrition is a significant concern, according to both local physicians and survey data. The region's obesity rate is 10% higher than the statewide

rate, and the incidence of diabetes is fully 20% higher (see Figure 1). More people in the Inland Empire report experiencing frequent mental distress compared with Californians generally, and more reported needing mental health treatment but not receiving care.[6] Perhaps as a result, the suicide rate in the region exceeds that of California more generally.[7]

FIGURE 1. Physical Health Indicators
Inland Empire vs. California, 2018



Sources: "AskCHIS," UCLA Center for Health Policy Research; "Preterm and Very Preterm Live Births," California Department of Public Health. Both sources accessed June 1, 2020.

Fewer Inland Empire Residents Have Private Health Insurance

Because of the expansion of Medi-Cal under the ACA, as well as improving economic conditions before the COVID-19 pandemic, the number of Inland Empire residents going without health insurance declined significantly in recent years. The uninsured rate prior to the pandemic stood at just 8.9% — compared with 7.7% statewide — largely as a result of increases in the Medi-Cal program, which covers 1 in 3 people in the region (see Table 2).[8] The region continues to sustain a lower-than-average rate of private insurance and higher-than-average rate of Medi-Cal coverage, despite the significant job growth noted previously.

TABLE 2. Trends in Health Insurance, by Coverage Source
Inland Empire vs. California, 2015 and 2019

	INLAND EMPIRE		CALIFORNIA	
	2015	2019	2015	2019
Medicare*	13.2%	14.5%	14.4%	15.9%
Medi-Cal	33.5%	33.1%	29.1%	28.7%
Private insurance†	43.9%	43.5%	47.8%	47.7%
Uninsured	9.4%	8.9%	8.6%	7.7%

*Includes those dually eligible for Medicare and Medi-Cal.

† Includes any other insurance coverage (excluding Medicare and Medi-Cal).

Source: Calculations made by Blue Sky Consulting Group using data from the US Census Bureau, the Centers for Medicare & Medicaid Services, and the California Department of Health Care Services.

Overall, health insurance coverage in the region is dominated by two players: IEHP, which covers about one-fourth of the region's population through the Medi-Cal program, and Kaiser Permanente, which covers an additional quarter of the population, primarily in the commercial and Medicare markets.[9]

Most coverage for Medi-Cal enrollees is provided under the Two-Plan Model, with care provided by one public plan and one private plan. IEHP, the public plan created by Riverside and San Bernardino Counties, covers 89% of managed care enrollees (about 1.3 million people); Molina Healthcare, the private plan, covers the remaining 11% of enrollees. The plans' market shares have remained relatively stable in recent years, although enrollment for both plans has grown as Medi-Cal eligibility expanded.[10]

Most Inland Empire Medicare beneficiaries are enrolled in generally lower-cost Medicare Advantage (MA) plans.[11] Statewide, MA accounts for 44% of beneficiaries, while nearly 59% of Inland Empire beneficiaries opt for MA. Kaiser covers 31% of MA enrollees, with UnitedHealthcare (19%) and SCAN Health Plan (12%) also accounting for significant market share.

Although Kaiser's total enrollment has increased as the region's population has grown, its market share has not changed significantly over the past several years. Nevertheless, Kaiser continues to play a dominant role in the region, effectively competing for patients and new providers

and adding capacity through a planned hospital expansion, new clinics, and a new medical school.

Kaiser also has a large share of Inland Empire enrollment on the state's health insurance exchange, Covered California, with just over one in four enrollees choosing Kaiser. Other large regional players in this market include Health Net, with more than 40% of enrollment, followed by Blue Shield of California, with almost 24% of enrollment.[12]

Overall, the share of Inland Empire residents enrolled in Covered California plans is smaller than the share of Californians generally enrolled in those plans (see Table 3). And while premiums in the Inland Empire are less expensive than the statewide average ($408 for a silver plan policy compared with the statewide average of $454), a recent analysis suggests that the region's *wage-adjusted* average silver plan premium is in fact more expensive than the statewide average, given the region's lower incomes.[13] In addition, both inpatient and outpatient procedures in the Inland Empire's hospitals are, on a wage-adjusted basis, relatively less expensive than in other regions, perhaps in part because of the hospital market's lack of consolidation.[14]

TABLE 3. Covered California Premiums and Enrollment
Inland Empire (Region 17) vs. California, 2015 and 2019

	REGION 17		CALIFORNIA	
	2015	2019	2015	2019
Monthly premium (Silver Plan on the exchange for a 40-year-old individual)	$278	$408	$312	$454
Percentage of population enrolled	2.3%	2.3%	3.0%	3.1%

Source: Blue Sky Consulting Group analysis of data files from "Active Member Profiles: March 2019 Profile" (as of May 31, 2020) and "2019 Covered California Data: 2019 Individual Product Prices for All Health Insurance Companies," Covered California.

Provider Trends

Data suggest a relatively large share of care in the Inland Empire is delivered by independent physicians in solo or small group practices. According to interviewees, this landscape is evolving, as small practices struggle to recruit new clinicians and more care is delivered by FQHCs, while larger medical groups continue to expand their reach in the region. The region's hospital market remains relatively stable, with no mergers or significant changes in hospitals' market shares over the past several years, although several hospitals have closed pediatric units. Respondents noted that, particularly among hospitals, more traditional payment methods prevail, with most hospitals in the region reluctant to take on financial risk. Most physicians in private practice caring for Medi-Cal patients reportedly receive fixed per-member, per-month payments for their professional and related services, under the system known as capitation, as well as P4P incentives, which account for a significant share of revenue. According to interviewees, some larger organizations have assumed full risk, primarily in the Medicare Advantage market, but also for some commercial payers.

Independent Physician Practices Are Common

Data suggest the Inland Empire's primary care and specialty care provider landscape remains relatively unconsolidated compared with the rest of California, with many independent physicians in solo or small group practices delivering care throughout the region. More physicians in the Inland Empire than in the state as a whole practice in settings that are not owned or controlled by hospitals or health systems; this disparity is somewhat more pronounced among primary care physicians (see Table 4). Within the Medi-Cal market, more than 40% of all physicians who contract with IEHP do so directly and not through an independent practice association (IPA) or medical group.[15]

TABLE 4. Physicians in Practice Owned by a Hospital or Health System
Inland Empire vs. California, 2019

	Primary care physicians	Specialists
Inland Empire	31%	47%
California	43%	53%

Source: Blue Sky Consulting Group calculation of population-weighted regional and state averages from Richard M. Scheffler, Daniel R. Arnold, and Brent D. Fulton, *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, California Health Care Foundation, October 2019.

As a result of the large number of independent practices, the Inland Empire ambulatory care sector remains relatively unconcentrated. Riverside County's primary care market is the second least concentrated of 58 counties statewide, while San Bernardino County's market is the 12th least concentrated.[16] The region's specialist markets also are relatively unconcentrated when compared with the rest of California; Riverside has the third-lowest and San Bernardino the fourth-lowest market concentration in the state.

The large number of independent providers and practices offers a range of choices to residents and autonomy for providers but, according to interviewees, may also slow innovations that are taking hold in other markets across the state, particularly with respect to the use of data to drive performance improvement and clinical integration. The region's geography, as well as its physician shortage (see Clinician Shortages on page 13), may prevent competition among providers necessary to spur these changes. As one administrator put it, "there are pockets with low access, and providers haven't had to innovate because they're the only game in town."

Although care delivery has long been dominated by small, independent practices, respondents note this landscape may now be shifting as financial pressures, market conditions, and demographics all combine to put pressure on solo and small practices. While increasing use of quality improvement incentives can help to improve patient outcomes, use of these incentives also has increased pressure on independent practices to better track and utilize data in clinical practice. According to several medical group leaders, these practices must not only compete with FQHCs and their more generous reimbursement rates for Medi-Cal patients but also invest in adoption and use of EHR systems and data analytics needed to qualify for most P4P incentives. One small medical group manager noted having "to scrape and fight to stay in business" amid the financial pressures and competition from FQHCs.

Interviewees noted that without the economies of scale offered by a large medical group or network of FQHCs, these investments can be difficult for small practices to absorb. In addition, many younger physicians increasingly prefer an employment relationship and are therefore drawn to Kaiser, FQHCs, and larger medical groups. Although the region has not witnessed significant growth in the hospital-based medical foundation model, which has led to consolidation of primary care providers in other regions, the combination of increasing financial and demographic pressures may continue to propel growth away from solo and small practices toward larger organizations.

These market forces may benefit some of the region's largest IPAs and medical groups. OptumCare, through its subsidiaries PrimeCare and North American Medical Management (NAMM) California, provides care for approximately 440,000 assigned patients in the commercial, MediCare, and Medi-Cal markets (or roughly 10% of the region's insured population). PrimeCare is the largest IPA in the Inland Empire. Together with NAMM, PrimeCare has a network of approximately 650 primary care providers and takes full risk for MediCare Advantage and some commercial enrollees. PrimeCare and NAMM have continued a steady expansion in the region over the past several years, including the 2016 acquisition of the Inland Faculty Medical Group, a large IPA serving Medi-Cal enrollees. Other recent additions include the Empire Physicians Medical Group in the Coachella area; San Bernardino Medical Group, an 18-physician multispecialty medical group with locations in San Bernardino and Fontana; and the Riverside Physician Network, with 60 primary care physicians.[17]

Other major physician organizations primarily serving commercially insured patients include Beaver Medical Group, with about 220 physicians, and Riverside Medical Clinic, with 135. Beaver additionally owns EPIC Management, which provides administrative, information technology (IT), and management support to Beaver and eight other medical groups. EPIC Health Plan, a subsidiary of EPIC Management, covers more than 70,000 commercial enrollees (or about 4% of the Inland Empire's privately insured population), taking

on global financial risk and contracting with primary and specialty care providers and hospitals on a capitated and fee-for-service basis.

The region has also participated in a handful of accountable care organizations (ACOs) formed by the major commercial health plans. Blue Shield of California's Trio ACO network, established in 2016, now includes both PrimeCare and Beaver, as well as several other smaller physician groups and many regional hospitals. PrimeCare has similarly partnered with national carrier Aetna to establish Aetna Whole Health in the Inland Empire. As of 2018, the partnership's payment model included incentives tied to quality, efficiency, and patient satisfaction.

Outside of the Inland Empire's urban core, the affiliated Choice Medical Group (CMG), Horizon Valley Medical Group, and Choice Physicians Network are responsible for more than 40,000 people in the high desert area, including 20,000 Medi-Cal enrollees. Another larger provider in the region is the Heritage Provider Network (which also covers other areas across Southern California). Its affiliates, Heritage Victor Valley Medical Group, with 45 primary care providers, and Desert Oasis Healthcare, with 67, serve the high desert and Coachella Valley areas.[18]

Aside from the independent physicians contracting directly with IEHP — who collectively provide care for nearly half of all IEHP members — other large Medi-Cal providers in the region include the Inland Faculty Medical Group, Alpha Care Medical Group, and Kaiser. The Inland Faculty Medical Group includes 239 primary care providers and 230,000 Medi-Cal enrollees (or about 15% of the region's Medi-Cal population).[19] Alpha Care Medical Group provides care for nearly 165,000 IEHP Medi-Cal enrollees (or about 13% of IEHP's enrollees). Kaiser is another large Medi-Cal provider, with 110,000 members; Kaiser provides Medi-Cal coverage under an IEHP subcontract while limiting Medi-Cal enrollment to previous Kaiser members or family members. The Medi-Cal provider landscape saw a shift in 2018 when IEHP terminated its contract with Vantage Medical Group and reassigned nearly 275,000 patients to other providers. The region's FQHCs covered nearly 400,000 Medi-Cal lives (about 1 in 4 Medi-Cal enrollees) as of 2020, with Borrego Health, Riverside University Health System (RUHS), and SAC Health System among the largest providers.

FQHC Expansion

According to respondents, among the most notable recent Inland Empire trends is the rapid growth of FQHCs. In recent years, the number of FQHC patient visits, or encounters, more than doubled, increasing from just under 500,000 in 2014 to more than 1.2 million in 2018 (statewide, there were about one-third more FQHC patient encounters per capita during this period).[20] FQHCs now provide primary care for roughly one-third of the region's total Medi-Cal population.

FQHCs are eligible for enhanced Medi-Cal payments, student loan repayment programs, and federal operational and capital grants.[21] Growth in the region's FQHCs was driven in part by the expansion of FQHCs from neighboring counties, such as San Diego–based Borrego Health, which now has 17 health center locations across Riverside and San Bernardino Counties and accounts for roughly half of all non-county-run FQHC patient visits, and Neighborhood Healthcare, which started in Escondido and now has four Inland Empire locations and accounts for 6% of all non-county FQHC visits. SAC Health System, with a half dozen locations across the Inland Empire (as well as mobile health and dental units), accounts for nearly 10% of all non-county FQHC encounters in the region and boasts more than 35 unique specialties. The county-run clinic systems also continue to provide a significant share of primary care services to the Inland Empire's low-income residents. RUHS operates 12 FQHCs across Riverside County that together saw nearly 63,000 patients in 2019.[22] San Bernardino County operates four FQHCs that served more than 10,000 patients. The growth of FQHCs represents a significant expansion of the Inland Empire's safety net, historically an area of concern for the region.

Despite the recent FQHC expansion in the Inland Empire, on a per capita basis, the number of FQHC visits per person in the region was half the state average, up from one-third of the state average in 2014 (see Table 5).

TABLE 5. Federally Qualified Health Centers
Inland Empire vs. California, 2014 to 2018

	INLAND EMPIRE		CALIFORNIA	
	2018	Change from 2014*	2018	Change from 2014*
Patients per capita	0.07	91%	0.15	29%
Encounters per capita	0.26	137%	0.51	35%
Operating margin	–5.7%	0%	2.1%	–1%

*Reflect the percentage change in patients/encounters per capita, and the absolute change in margins.

Notes: Includes FQHC Look-Alikes, community health centers that meet the requirements of the Health Resources and Services Administration Health Center Program but do not receive Health Center Program funding. Patients may be double counted if they visit more than one health center.

Sources: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development; "County Population by Characteristics: 2010–2019," US Census Bureau. All sources accessed June 1, 2020.

Moreover, an analysis of data from the Office of Statewide Health Planning and Development (OSHPD) shows that FQHC operating margins in the Inland Empire remained flat between 2014 and 2018, despite a reduction in care provided to uninsured people. In 2014, 6% of FQHC patients received free care, with an additional 29% paying a sliding fee based on income. In 2018, these groups accounted for 1.5% and 13.5%, respectively, of the FQHC patient population. In spite of the reduction in care for the uninsured, expenses per encounter increased during this period along with revenues, leaving operating margins unchanged from 2014.

The growth of FQHCs and other health centers in the region likely stems in part from the ACA's Medi-Cal expansion, given that FQHCs predominantly serve Medi-Cal patients, and this regional growth mirrors the larger statewide trend. Respondents note that FQHC growth in the Inland Empire may also be driven in part by the underlying characteristics of the provider landscape — notably the relatively large share of care for Medi-Cal patients provided by independent medical practices. The relatively small share of care previously delivered by health centers, along with the financial struggles of independent practices serving Medi-Cal patients, may have facilitated FQHC expansion through both acquisition of and successful competition for patients with independent practices. As one observer noted, FQHCs are "Hoovering up private practices" across the region.

Hospital Finances Improve; Market Remains Unconsolidated

According to OSHPD data, the Inland Empire is served by 38 hospitals, including county hospitals in both Riverside and San Bernardino, as well as investor-owned, nonprofit, and district hospitals. Twelve hospitals are independent, accounting for nearly 30% of all discharges, with the remaining hospitals belonging to smaller local systems, such as Loma Linda University Health, or larger statewide or national networks, such as Kaiser Permanente and Universal Health Services.

The hospital sector in the Inland Empire remains relatively unconcentrated when compared with other markets across California. And according to several measures of market share — licensed bed days, discharges, and outpatient visits — hospital market concentration in the Inland Empire has not changed markedly in recent years. None of the region's hospitals has merged with or acquired other hospitals in the region over the past several years, and no hospital or system accounts for more than 13% of all discharges. A commonly used measure of market concentration shows San Bernardino County and Riverside County as having, respectively, the second- and third-lowest levels of hospital market concentration of all California counties, behind only Los Angeles.[23]

Given the region's geography, however, assessing concentration based on each system's share of the total regional market may overstate the degree of fragmentation, because some hospitals are dominant players in their submarkets. For example, Tenet Healthcare Corporation, which operates three hospitals in the more sparsely populated eastern half of Riverside County, accounts for only 9% of all Inland Empire discharges but a far larger percentage of those in the local area (hospitals in the city of Riverside are more than an hour's drive away). Similarly, for a large portion of San Bernardino County's high desert community, Barstow Community

Hospital is the only hospital outside of Victorville, which is more than 30 minutes to the south. While not isolated geographically, Loma Linda University Medical Center is a prominent academic medical center and, as one of the area's two Level I trauma centers, provides a large amount of advanced specialty care. Nevertheless, the region has not experienced the consolidation of hospitals into large systems that has characterized the rest of the state.

The region's largest hospitals and hospital systems include the following.

Loma Linda University Medical Center serves as a key safety-net provider. The wider hospital system, with more than 1,100 licensed beds spread over six hospitals, accounted for 13% of the region's overall discharges and 16% of Medi-Cal discharges in 2018. Loma Linda operates a children's hospital with 343 beds, including 84 in its neonatal intensive care unit. The children's hospital is adding a new tower in 2021, which will offer a children's cardiovascular lab and pediatric emergency department (ED). Loma Linda's main site includes one of the region's two Level I trauma centers. Also part of the system is a separate surgical hospital, as well as a behavioral medicine center, which provides both inpatient and outpatient behavioral health services.[24] In addition to the hospital system, Loma Linda provides financial support to SAC Health System, an FQHC that runs clinics in six locations and is among the largest teaching health centers in the country.[25] The relationship between Loma Linda and SAC Health System dates to 1960, when university staff and students founded the Social Action Corps as part-time volunteers and offered temporary medical clinics in the community. The two have partnered to provide pediatric care at Loma Linda University Children's Health–Indio clinic, and in 2016 SAC Health System established a new facility at the university's campus in San Bernardino, which is also home to a health professionals training program.[26]

Kaiser operates four hospitals in the Inland Empire's urban core and surrounding suburbs — in the communities of Ontario, Fontana, Riverside, and Moreno Valley. Kaiser hospitals accounted for 12% of total discharges in 2018, including nearly 28% of all commercial payer discharges. Observers note that these metrics may understate Kaiser's total market coverage, however, given Kaiser's preventive health focus, which aims to reduce patients' reliance on hospital care. Kaiser has plans to expand acute inpatient capacity from the current 94 beds to an eventual 460 beds at Kaiser's Moreno Valley location in Riverside County.[27]

Universal Health Services (UHS), a large investor-owned hospital system with acute care facilities in seven states, operates four hospitals in the region, including three in the southwestern corner of Riverside County. UHS has experienced the largest increase in hospital market share in recent years and is now the third-largest system in the region, accounting for 10.5% of acute care discharges in 2018, up from 7.5% in 2014. UHS's Temecula Valley location added a 28,000-square-foot wing in 2018 with space for cardiovascular and neuroscience services.[28] UHS also operates a psychiatric hospital at the western edge of the Inland Empire, providing nearly one-third of the region's psychiatric beds.

Dignity Health, which is part of a large multihospital system operating in 21 states, operates Community Hospital of San Bernardino and St. Bernardine Medical Center and serves as the region's other key nonprofit safety-net provider. The two hospitals account for 7% of total discharges and 11% of Medi-Cal discharges. St. Bernardine's is home to the Inland Empire Heart & Vascular Institute.

Riverside University Health System–Medical Center, the county hospital for Riverside, and **Arrowhead Regional Medical Center (ARMC)**, the county hospital for San Bernardino, together account for only 11% of total acute discharges but play a key safety-net role, providing 19% of Medi-Cal discharges. RUHS's medical center, which fits under a broader county umbrella that also includes 12 FQHCs as well as the county Departments of Behavioral Health and Public Health, recently opened a new 200,000-square-foot medical office building for primary care and specialty groups.[29] RUHS also expanded its ED and became a Level I

trauma center.[30] RUHS's FQHCs care for roughly 95,000 IEHP-assigned Medi-Cal enrollees. ARMC offers a Level II trauma center and burn center and provides primary care services through four family health clinics.

Although the region's population has continued to grow, hospital capacity remained relatively stable between 2014 and 2018, with hospitals' staffed bed count increasing by just 1%. More recently, however, Parkview Community Hospital, purchased by AHMC Healthcare Inc. in 2019, expanded its ED from 13 to 41 beds, and Riverside Community Hospital added more than 100 beds at a new seven-story patient tower as well as 14 ED beds.[31] Redlands Community Hospital is tripling the size of its ED by adding 12 beds, critical care rooms, and a dedicated psychiatric care space.[32] And more capacity is expected, as Kaiser plans an expansion in Moreno Valley from 94 to 460 beds. Although the number of hospital beds has increased only modestly, the region's hospital occupancy rate remains similar to the statewide average (with the exception of beds for psychiatric patients, which are in short supply in the Inland Empire).

These hospital expansions have been accompanied by a series of pediatric unit closures over the past several years. Most recently, Riverside Community Hospital administrators announced the November 2020 closure of the hospital's pediatric unit, stating that the move was the result of declining patient volumes. This announcement followed several similar closures, including at Kaiser Permanente Riverside Medical Center, Corona Regional Medical Center, and St. Bernardine Medical Center, which also stemmed from low patient volumes and a desire to lower costs. Although these closures may mean that children are treated at facilities that are better able to specialize in pediatric inpatient hospitalization, some pediatricians have expressed a concern that their patients may need to travel farther to receive care.

According to respondents, meeting state seismic standards remains a consideration for area hospitals, as it does for hospitals statewide. Among the region's smaller hospitals, accessing capital to make needed improvements is a continuing obstacle, likely worsened by financial pressures from the COVID-19 pandemic. Some of the region's larger hospitals, however, are reportedly better positioned. Both county hospitals were previously rebuilt to comply with state seismic standards. Loma Linda University Health is nearing completion of a new Medical Center tower and a Children's Hospital tower. Kaiser, with its newer facilities, is also generally well positioned, as is St. Bernardine Medical Center, which has undergone seismic upgrades.

Stronger Financial Performance

According to OSHPD data, in the year prior to the COVID-19 outbreak, Inland Empire hospitals were enjoying much stronger financial performance than in previous years. Along with rising employment and health insurance coverage, hospital profitability during 2014–2018 improved. Across all hospitals in the region, the average operating margin rose from –0.2% in 2014 to 2.2% in 2018 (statewide margins improved from 2.5% to 4.6% over this period, as shown in Table 6).

TABLE 6. Hospital Performance (Acute Care)
Inland Empire vs. California, 2018

	Inland Empire	California
Beds per 100,000 population	158	178
Operating margin*	2.3%	4.4%
Paid FTEs per 1,000 adjusted patient days*	15	15
Total operating expenses per adjusted patient day*	$3,088	$4,488

*Excludes Kaiser.

Note: *FTE* is full-time equivalent.

Sources: "Hospital Annual Financial Data - Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development; "County Population by Characteristics: 2010–2019," US Census Bureau. All sources accessed June 1, 2020.

Several factors may help explain this trend. First, largely because of the expansion of Medi-Cal under the ACA, hospital losses attributable to providing uncompensated care decreased, with this category accounting for only 1.4% of all visits in 2018, down from 6.7% in 2014. (This decrease was less pronounced statewide, with the rate falling from 4.9% to 1.8%.) Second, serving Medi-Cal patients grew more profitable. While hospitals reported that Medi-Cal managed care visits remained, on net, a financial drain (with expenses

exceeding net patient revenue), the average payment shortfall per discharge fell dramatically. For traditional fee-for-service Medi-Cal patients — who account for 14% of all discharges and 18% of net patient revenues — net patient revenues per patient day increased substantially.

IEHP — Strong Market Position Amplifies P4P Initiatives

IEHP, the region's largest Medi-Cal managed care plan, covers nearly 9 in 10 Medi-Cal patients in the Inland Empire — equivalent to more than a quarter of the region's population. With more than 1.3 million members and more than 6,000 network providers, many respondents noted that IEHP is a dominant force in the Inland Empire health care landscape. The health plan's strong position reportedly offers considerable leverage in negotiating contracts with the region's hospitals and other providers. However, IEHP's leverage is tempered by the relative lack of providers, especially in the region's eastern areas, where many hospitals and providers are "must haves" for IEHP to maintain an adequate provider network. Interviewees noted that this combination of balanced market forces and consensus among providers that IEHP is a "good partner" in delivering care to the region's Medi-Cal population results in generally positive relationships between IEHP and the provider community.

By its own estimate, IEHP has contracts in place with more than half of the region's primary care physicians and roughly 40% of specialists. Interviewees noted that IEHP has significant leverage in encouraging providers to utilize data to drive performance and implement new quality improvement programs. IEHP reports paying most primary care providers on a capitated basis, with additional payments in the form of performance-based quality improvement incentives comprising 10% to 25% of Medi-Cal revenue. For many physicians, IEHP is the sole Medi-Cal plan with which they contract; as a result, earning P4P incentives is reported to be somewhat simpler in the Inland Empire because only one plan's rules must be followed (unlike counties with many competing plans and accompanying incentive schemes). Still, IEHP's efforts at implementing data-informed practices may be complicated by the region's size and large number of independent practices.

In recent years, IEHP has implemented several quality improvement initiatives — in addition to its global pay-for-performance program. For example, IEHP incentive payments encouraged hospital participation in the region's health information exchange (HIE), Manifest MedEx, which is now widely used by virtually all hospitals in the region. IEHP also implemented a shared-saving pilot that enabled participating primary care providers to earn up to 60% of any savings IEHP realized in paying for referred services, including hospital visits.[33] Most recently, IEHP has started assigning patients to providers based on the provider's clinical performance, with more effective providers rewarded with additional patient assignments.

Using Data to Drive Performance Improvement

The use of data to improve patient outcomes and lower costs has been gaining ground in the region and across the state. In the Inland Empire, many providers participate in at least some forms of data sharing, whether through use of a shared EHR system; participation in the region's health information exchange, Manifest MedEx; or delivery of care in an integrated system such as Kaiser or RUHS.

Data Sharing Increases Across Region

Formed in 2017, Manifest MedEx has made inroads in establishing connections among hospitals, health centers and clinics, and providers. IEHP encourages hospital participation through its hospital P4P program, which includes financial incentives to share data through the platform. As a result, nearly all hospitals in the region now provide event notification (admission, discharge, and transfer, or ADT) data. The region is also home to the Inland Empire Health Information Organization, a nonprofit designed to connect providers to Manifest MedEx and coordinate data sharing and use

of population health analytics. IEHP is funding an effort to incentivize independent practices to migrate to one of a small set of cloud-based EHR systems that would be integrated with Manifest MedEx.

In addition to use of the HIE, interviewees noted that partnerships between community providers and hospitals, at least where they share a common EHR system, are further driving improvements in data sharing in the region. For example, RUHS shares a common EHR system, Epic, across its flagship hospital, 12 FQHCs, and other sites across the county, including Loma Linda University Medical Center and SAC Health System. Users of Epic can gain access to patient records within the same EHR system using functionality known as Care Everywhere. San Bernardino County's hospital, ARMC, will also reportedly transition to Epic in the future, furthering the potential for information sharing among providers.

Health plans are also reportedly playing a role in collecting and disseminating information, offering gap-in-care reports to providers and information about patient prescriptions and specialist visits, among other types of information. For example, IEHP provides gap-in-care reports directly to all primary care providers, whether they work directly with the health plan or contract through an IPA. IEHP also provides information on prescriptions and other data through the member health record that is attached to eligibility verifications performed on the IEHP secure provider portal. Finally, the trend toward care delivery through larger medical groups and integrated systems may offer more providers the support of dedicated IT teams and access to integrated EHR systems, which observers expect to improve access to and use of patient data.

Challenges Remain

Interviewees noted that, despite progress on data sharing in the region, participation is primarily concentrated among hospitals and some large medical groups, with far less participation among smaller independent practices. As one clinic administrator noted, the "HIE is still a work in progress with lots of holes left to fill." For some practices, the IT complexity and cost of linking their EHR system to Manifest MedEx are prohibitive. For others that do participate, the additional task of regularly accessing and utilizing the available data requires staff training and changes in workflow that some perceive as too costly or burdensome. Even for larger medical groups or health centers, truly integrating and using data to improve care requires that offices hire new staff to monitor metrics, track referrals, and ensure that patients are following treatment plans. Physicians and support staff must undergo additional training, and the new operating procedures become a part of the routine workflow only over time.

To address some of the challenges associated with data sharing, some larger medical groups and IPAs in the region report employing dedicated data teams to collect and process internal data and work with partner providers and hospitals to collect and share information. Some of these in-house data teams collect and process patient records in a largely manual process — "chart scrubbing," as one provider called it — to ensure information is available to monitor patient care. Tools developed by these organizations to coordinate across a broad range of hospitals and specialists in the region include stationing case managers in hospitals and using hospitalists to coordinate and deliver care to hospitalized patients and help keep primary care providers informed about their hospitalized patients. Even at larger institutions, administrators noted that data analytics initiatives are still in their early stages and that more must be done to build out the teams responsible for incorporating data into routine clinical practice.

Data sharing in the region may be further hampered by the fragmentation in the region's hospital and ambulatory care sectors. This fragmentation contributes to the wide array of sometimes siloed EHR systems used across the region, which may not be integrated with information from the HIE or have the capacity to communicate with EHR systems used by other practices. Smaller practices in the region are also less

likely to participate in larger EHR systems such as Epic that allow for data sharing with other users on the same system (as well as offering HIE integration with the EHR system).

Behavioral Health

Behavioral health care, which includes both mental health and substance use disorder services, remains an important issue throughout the region, with one observer noting that "behavioral health is a huge challenge." More Inland Empire residents report experiencing frequent mental distress compared with Californians generally, and more Inland Empire residents needed but did not receive mental health treatment.[34] In line with the region's general lack of access to specialty care, the Inland Empire is home to only eight psychiatrists per 100,000 residents, the second-lowest ratio across the seven study markets. In addition, people with behavioral health needs often suffer from poorer physical health and may also lack access to adequate physical health care services. Interviewees noted that, in response, many providers in the region, including many FQHCs, have sought to integrate physical health and behavioral health care services. This transformation has been slower to take hold among many of the region's independent providers, and access to psychiatric services remains a daunting obstacle.

Respondents note that much of the innovation surrounding behavioral health care in the region has occurred in the Medi-Cal program. For most Medi-Cal enrollees needing nonspecialty services (that is, those with lower-acuity conditions), coverage is administered by their managed care plan, while county behavioral health departments are responsible for adults with serious mental illnesses and children with serious emotional disturbance. Some FQHCs in the region offer integrated behavioral health care (generally for lower-acuity conditions) from a behavioral health provider located within a physical health clinic. In addition, IEHP has been encouraging the integration of behavioral health with routine clinical care.

IEHP has launched several initiatives to improve behavioral health care integration, including complex care management teams to aid patients with physical, behavioral, social, and environmental needs. One such effort is the Behavioral Health Integration Complex Care Initiative (BHICCI), a partnership between 30 local health centers and clinic sites and IEHP, with a goal of improving Medi-Cal enrollees' health outcomes by providing care management and care coordination for physical and behavioral health needs across multiple providers and health care systems.[35]

IEHP and the San Bernardino County Department of Behavioral Health have also explored ways to better integrate physical and behavioral health services, while Riverside County operates an integrated system consisting of its hospital, outpatient clinics, and behavioral health department (as well as the public health department). With all of these service providers reporting to the same leadership, the county seeks to improve integration across specialties and improve patient care.

Clinician Shortages

According to almost all respondents, access to care continues to be a significant issue in the Inland Empire as the region consistently struggles to recruit both primary care clinicians and specialists, as well as other health care professionals. Indeed, one observer said that the region "will never be able to bridge the gap in workforce shortage," noting that "the region is already behind and the population is growing."

While many factors contribute to recruitment difficulties, respondents note that competition with more geographically attractive neighboring regions, such as Los Angeles, Orange, and San Diego Counties with their greater access to the beach, cultural amenities, and educational and employment opportunities for clinicians' family members, likely contributes to the challenge. The access challenges caused by lower numbers of clinicians are exacerbated by the Inland Empire's sprawling geography, resulting in long patient travel times for care, especially specialist visits. Observers

are optimistic that the recent introduction of new medical schools may help mitigate this challenge in the future.

Inland Empire Faces Severe Physician Shortage

According to analysis conducted for this study by the University of California, San Francisco, the Inland Empire has fewer primary care and specialty physicians per 100,000 residents than other California regions. The region has just 42 primary care physicians per 100,000 residents, compared with 60 statewide, and just 83 specialists per 100,000 people, compared with 131 statewide (see Table 7). Moreover, even these metrics obscure significant intraregional disparities in health care access. There are far fewer physicians per capita in the Inland Empire's eastern regions than in more densely populated communities near the counties' western borders. Based on designations by the Health Resources and Services Administration, nearly 30% of the region's population lives within a Health Professional Shortage Area (HPSA). The largest of these is the Hemet–San Jacinto area, 35 miles southeast of the city of San Bernardino. The others are in the mountains or high desert and include Adelanto/Victorville, Hesperia, Joshua Tree, Colton, Barstow, and Canyon Lake. In addition, because of both the geographic spread and lower average incomes, the travel required to access care in the region can present a significant barrier. According to respondents, those living in the eastern part of the region may have to drive two or more hours to receive care from certain specialties.

TABLE 7. Physicians: Inland Empire vs. California, 2020

	Inland Empire	California	Recommended Supply*
Physicians per 100,000 population†	125.3	191.0	—
► Primary care	41.5	59.7	60–80
► Specialists	83.3	130.8	85–105
► Psychiatrists	8.2	11.8	—
% of population in HPSA (2018)	29.6%	28.4%	—

*The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include doctors of osteopathic medicine (DOs) and are shown as ranges above.

† Physicians with active California licenses who practice in California and provide 20 or more hours of patient care per week. Psychiatrists are a subset of specialists.

Sources: Healthforce Center at UCSF analysis of Survey of Licensees (private tabulation), Medical Board of California, January 2020; and Health Professional Shortage Area (HPSA) data from *Shortchanged: Health Workforce Gaps in California*, California Health Care Foundation, July 15, 2020.

Survey data confirm that residents can struggle to access care. Nearly 25% of Inland Empire residents reported that they are "never" able to schedule a doctor's appointment within two days, compared with 15% of people statewide. Access remains a challenge in the Medi-Cal population as well, with nearly 29% of Medi-Cal patients reporting that they had not had a routine checkup within the previous 12 months, compared with 23% statewide. Access to specialists is more challenging for the region's Medi-Cal patients: 26% reported having their insurance turned down by a specialist, compared with 20% of Medi-Cal patients statewide.[36]

Among providers participating in this study, there is widespread skepticism that the region will ever substantially fill this gap by recruiting doctors from other regions. California's larger cities are perceived as offering more amenities and better practice opportunities for more highly specialized physicians, which makes recruitment, particularly in the region's eastern areas, difficult. As a result, those seeking to recruit physicians emphasized the importance of developing the Inland Empire's local medical student pipeline and tapping personal connections to attract friends and acquaintances to work in the region. Data from the Bureau of Labor Statistics also shows that physician salaries for some specialties are higher in the region compared with nearby areas such as Los Angeles and San Diego, suggesting that recruiting challenges may have driven up physician pay rates.[37]

In addition, IEHP's Provider Network Expansion Fund (NEF), established in 2014, awards $30 million to attract physicians and midlevel practitioners to the Inland Empire. The NEF pays 50% of a recruited physician's salary for one year, up to $100,000 for a primary care physician or $150,000 for a specialist.[38] IEHP reports that, to date, NEF has led to the recruitment of more than 300 physicians and midlevel practitioners.[39] IEHP also developed a $40 million scholarship fund to help health care professionals reduce school debt.

New Medical Schools May Lessen Physician Shortages

According to respondents, while an aging workforce threatens to further limit health care access, the arrival of new medical schools may mitigate this trend, although additional residency programs also may be needed to help retain additional graduates in the local area. The region's largest medical school, founded in 1909, is Loma Linda University School of Medicine, which graduated 140 students in 2020. Many graduates remain in the Inland Empire to practice.

The following recent and upcoming medical school openings in or close to the region may help to expand the Inland Empire physician pipeline:

University of California, Riverside (UCR) School of Medicine, Riverside: UCR's first class of 40 students graduated in 2017. Later classes have included 50 students, and recent funding increases approved as part of the state's 2020–21 budget increased funding by $25 million, which will allow the school to increase the size of each incoming class to 125 students.[40] The school's mission is to improve the health of the people of the "Inland Southern California" region, with a focus on innovative health delivery programs designed to treat the underserved. The school also seeks to train physicians who will remain in the region. Of UCR's incoming class, roughly 50% previously resided in or have a family connection to the Inland Empire.

In part because of UCR's scholarship incentives, 25% of recent graduates chose to remain in the Inland Empire for their residency, and 70% remained in Southern California. The school has actively sought to encourage this behavior through incentive programs. Roughly 30 students currently receive the Dean's Mission Award, which covers two years of all required university fees. In exchange, graduates must practice for at least 30 months as a primary care physician in the Inland Empire or Imperial County. The First 5 Riverside scholarship covers four years of university fees, with the graduate obligated to practice as a pediatrician in the region for five years following graduation.[41] In addition to these programs, the medical school seeks to retain physicians in the region by providing opportunities for physicians to partner with the school — for example, through a faculty appointment or through the pursuit of continuing medical education.

California University of Science and Medicine (CUSM), San Bernardino County: Founded as a private, nonprofit medical school with ARMC serving as its teaching hospital, CUSM's first class entered in 2018, and the 2020 entering class is expected to have 120 students. CUSM "aims to provide opportunities to individuals from low-social-economic status; Inland Empire residents; and first-generation college students." Fourteen percent of students are Inland Empire residents.[42]

Keck Graduate Institute (KGI), Claremont: Located in Los Angeles County near the western border of San Bernardino County, KGI has not yet accepted its first class but, as of 2018, had secured funding to establish a new medical school just miles from the Inland Empire's western border. Noting the number of HPSAs for primary care in the region, the school's vision, in part, is to "increase population health, improve access to quality care, and lower healthcare cost. . . . We can effect systemic healthcare change — first within the San Gabriel Valley and Inland Empire areas, and then statewide and nationally."[43]

Kaiser Permanente Bernard J. Tyson School of Medicine, Pasadena: Located 50 miles from San Bernardino, Kaiser's first class, which entered in fall 2020, had 50 students. The school will waive tuition for all students entering prior to 2024, with additional grant aid available for those with demonstrated need.

Early Experience with COVID-19

According to respondents, the outbreak of COVID-19 in March 2020 (occurring as the interviews and data collection for this report were underway) swiftly reversed the financial gains made by hospitals in the preceding years and resulted in the temporary shuttering of many health centers and smaller physician practices. Moreover, the region's relatively less healthy and poorer population is more vulnerable to both the health effects and the economic fallout caused by COVD-19. According to interviewees, however, there have been some silver linings, with increasing adoption of telehealth and a renewed focus on the social determinants of health potentially offering long-lasting health benefits after the pandemic subsides.

In May 2020, Riverside and San Bernardino were each directly allocated more than $400 million from the federal government under the CARES (Coronavirus Aid, Relief, and Economic Security) Act. The counties reportedly spent the majority of this funding on further preparation for the pandemic — including additional medical supplies and personal protective equipment, construction of temporary facilities, testing, contact tracing, and financial assistance to hospitals — while much of the remainder was used to assist small businesses.[44] While the pandemic drove up unemployment rates across the state, its impact on the Inland Empire's economy was less than in other regions, with an unemployment rate that peaked at 14.3% in June, less than the statewide 15.1% rate (see Table 8).

TABLE 8. COVID-19 Impacts: Inland Empire vs. California

	Inland Empire	California
UNEMPLOYMENT RATE		
► Pre-pandemic (FEBRUARY 2020)	4.0%	4.3%
► Mid-pandemic (OCTOBER 2020)	9.0%	9.3%
MEDI-CAL ENROLLMENT		
► Percentage change (FEBRUARY TO OCTOBER 2020)	3.8%	4.0%
CARES ACT, PER CAPITA (AUGUST 2020)		
► Provider Relief Funds	$92	$148
► High Impact Funds	$16	$16

Sources: Employment by Industry Data," State of California Employment Development Department; "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Health and Human Services, Open Data; and "HHS Provider Relief Fund," Centers for Disease Control and Prevention. CARES Act data accessed August 31, 2020; all other data accessed September 30, 2020.

Providers Face Ongoing Financial Pressures

Respondents noted that while nearly all physician practices and health centers faced revenue losses as COVID-19 forced them to reduce in-person visits, providers relying predominantly on fee-for-service payment have fared worse than others (although additional reimbursement from Proposition 56 funds available to Medi-Cal providers may have alleviated some financial pressure). Providers who rely on up-front capitated payments, which continued even in the absence of in-person medical visits, have been better able to maintain their revenue as patient visits declined. On the other hand, as nonessential visits, such as annual physicals, were halted for weeks or months, providers reported substantial worries about whether health plans will relax quality metrics needed to earn P4P incentives.

Interviewees noted that although claims-based revenues decreased while lockdown orders were in effect, Medi-Cal providers received a boost from IEHP. Under the plan's Physician Specialist Compensation Program, established in May 2020, physicians received up to 90% of the difference between the claims paid during the pandemic and the claims paid during the same period in 2019. IEHP introduced a similar relief measure for hospitals. Some commercial health plans also implemented initiatives to support providers in the

pandemic. For example, Blue Shield of California provided advanced payments to providers and financing guarantees to help them weather the pandemic.[45]

CARES Act relief funds, administered through the US Department of Health and Human Services, further mitigated the pandemic's financial impact. The county-run hospital systems were major beneficiaries, together receiving more than $70 million of the $343 million distributed to hospitals and other providers throughout the region.

Telehealth Gets a Boost

As in other markets, the pandemic forced a rapid transition in the Inland Empire toward use of telehealth services for patients' primary, specialty care, and behavioral health needs. Responding providers were generally supportive of this added flexibility, although some smaller providers reported technical challenges associated with adding this capability. Interviewees noted that telehealth may be particularly useful for behavioral health, even for the specialty mental health population served by county behavioral health departments. Though adoption had been slowed before the pandemic as a result of concerns that this population might have difficulty with telehealth, observers generally believe that both patients and providers have adapted well to telehealth, with one sign being lower "no-show" rates as fewer appointments are missed by patients. Some providers reported that they had already begun to develop the needed capacity for telehealth because of the region's historic difficulties with recruiting providers; this head start helped to facilitate the transition during the pandemic.

Interviewees noted that given the long travel times faced by Inland Empire patients, telehealth may be particularly important going forward. Following an initial transition period, some FQHCs were reporting that patient loads had climbed back to 60%–70% of pre-COVID-19 levels. Moreover, many specialist consultations do not require in-person visits.

While providers seem confident that telehealth is here to stay, concerns remain that the easing of restrictions on use of and payment for these services adopted during the pandemic may not be preserved in its aftermath. In addition, telehealth may not always reduce provider costs, to the extent that a telehealth visit takes longer than an in-person visit or requires a second, in-person visit as a follow-up after a telehealth visit.

Exacerbation of Provider Shortages

Across the state, the pandemic resulted in the delay of routine appointments and elective procedures. As clinics and hospitals fully reopen, respondents note that the Inland Empire's providers — already stretched thin by one of the lowest ratios of physicians to residents in the state — may find it difficult to meet pent-up demand, as patients seek to schedule the visits that had been delayed. Interviewees believe safety-net providers may bear the brunt of this impact, to the extent Medi-Cal rolls increase as the region's unemployment rate rises.

Fear of the virus could exacerbate the clinician shortage in other ways as well. As health center, physician practice, and hospital revenues fell during the initial wave of lockdowns, many health workers were laid off or furloughed. As providers reopen, some administrators noted that filling vacant positions could be difficult, given the infection risks faced by frontline staff.

Issues to Track

- How will the physician landscape evolve? Will the tendency of physicians to move from solo and small group practices to larger medical groups or FQHCs accelerate in the wake of financial pressures exacerbated by the COVID-19 pandemic?
- Will the hospital market move toward consolidation in the face of increasing cost pressures? If so, will consolidation increase economies of scale, give hospitals more leverage to negotiate higher payments from commercial insurers, or both?
- Will FQHC expansion continue and improve access to care for lower-income people and those with Medi-Cal coverage? Will telehealth play a larger role going forward in expanding access to specialty care, especially in the more rural, less affluent eastern areas of the Inland Empire?
- Will Manifest MedEx, the region's HIE, make inroads with providers, especially smaller physician practices, in overcoming obstacles to greater EHR system interoperability to harness the power of data analytics to transform clinical practice and improve outcomes and lower costs?
- Will efforts to integrate physical and behavior health services improve care coordination and ultimately health outcomes?
- What will result from the region's strategy of growing its own physicians through the opening of multiple new medical schools? As new medical school graduates enter practice, will opportunities in the Inland Empire outweigh potentially more attractive practice options elsewhere?
- How severe will the economic consequences of COVID-19 be for the region? How will safety-net services and initiatives fare in an era of budget cuts?

ENDNOTES

1. Information presented in this report is based on publicly available data sources as well as interviews with more than 20 local health care experts in the Inland Empire region.
2. "Employment by Industry Data," California Employment Development Dept., accessed July 2020.
3. *California Healthy Places Index*, Public Health Alliance of Southern California, accessed September 30 , 2020.
4. "Average One-Way Commuting Time by Metropolitan Areas," US Census Bureau, accessed September 30, 2020.
5. "Walkable Distance to Public Transit," California Health and Human Services Open Data Portal, accessed September 30, 2020.
6. 2019 data from *Ask*CHIS, UCLA Center for Health Policy Research, accessed November 12, 2020.
7. Blur Sky Consulting Group analysis of California Dept. of Public Health, "County Health Status Profiles 2019," accessed on September 30, 2020.
8. Estimates of the uninsured rate for each region are based on the Census Bureau's 2019 estimate of the uninsured rate in each county. The estimated share of the population enrolled in Medi-Cal is calculated as total Medi-Cal enrollment from California Dept. of Health Care Services data as of June 2019 (excluding those dually eligible for both Medi-Cal and Medicare) divided by US Census Bureau 2019 population estimates, aggregated for each region. Similarly, the estimated share of the population enrolled in Medicare is based on Medicare enrollment figures for 2019 published by the Centers for Medicare & Medicaid Services and US Census Bureau population estimates. The private insurance and all other insurance types category was calculated as the residual after accounting for those who were uninsured, enrolled in Medi-Cal, or enrolled in Medicare. See US Census, American Community Survey 1-Year Estimates, Table DP03, accessed June 2020 (for Census Bureau estimates of total county populations and uninsured rates); Dept. of Health Care Services, "Month of Eligibility, Medicare Status, and Age Group, by County, Medi-Cal Certified Eligibility," accessed June 2020 (for monthly Medi-Cal enrollment totals); and "Medicare Enrollment Dashboard," Centers for Medicare & Medicaid Services (CMS), accessed June 2020 (for Medicare enrollment data).
9. *Supplemental Report*, IEHP, August 2020.
10. *Managed Care Performance Monitoring Dashboard Report* (PDF), Dept. of Health Care Services, January 2020.
11. "Medicare Enrollment Dashboard," CMS, accessed October 2020.
12. "Active Member Profiles," Covered California, accessed June 2020.
13. Richard M. Scheffler, Daniel R. Arnold, and Brent D. Fulton, *The Sky's the Limit:Health Care Prices and Market Consolidation in California* (PDF), California Health Care Foundation, October 2019.
14. Ibid.
15. Meeting presentation (PDF), America's Physician Groups (APG) and Inland Empire Health Plan (IEHP), March 25, 2019.
16. Scheffler, Arnold, and Fulton, *The Sky's the Limit*.
17. "Riverside Physician Network Joins PrimeCare, Adding More Trio Provider Options for Your Inland Empire Groups," *LISI*, October 7, 2019.
18. "Physicians & Providers," Heritage Victor Valley Medical Group, accessed on September 30, 2020.
19. *Supplemental Report*, IEHP, August 2020.
20. As also noted in Table 5, encounter data are available only for non-county clinics. Including Riverside and San Bernardino Counties' clinic systems in this tally would increase the number of encounters.
21. "Health Center Program Look-Alikes," Bureau of Primary Health Care, Health Resources & Services Admininstration, accessed July 2020.
22. "Health Center Program Data," Health Resources & Services Administration, accessed August 2020.
23. A market's Herfindahl-Hirschman Index (HHI) is equal to the sum of the market share of each firm multiplied by 100 and squared. For instance, a market with two firms, each with 50% of the market, would yield an HHI of $50^2 + 50^2 = 5{,}000$. A market with four firms, each with 25% of the market, would yield an HHI of $25^2 + 25^2 + 25^2 + 25^2 = 2{,}500$. The HHI ranges from zero to 10,000, with higher scores indicating higher levels of concentration.
24. *Community Benefit Report — 2019* (PDF), Loma Linda University Health, 2019.
25. *Community Benefit Report — 2016* (PDF), Loma Linda University Health, 2016.
26. Sheann Brandon, "Loma Linda University Children's Health–Indio Celebrates One-Year Anniversary," Loma Linda University Health, March 14, 2019; Janelle Ringer, "New Healthcare Residents Get an Up-Close Look at San Bernardino County," Loma Linda University Health, June 25, 2019.
27. Robert Chevez, "Proposed Expansion of Kaiser Permanente," *Moreno Valley City News*, April 2, 2020.

28. *2019 Community Profile* (PDF), Temecula Valley Hospital, 2020.

29. "RUHS Begins Construction on Surgery Center, Medical Offices," *Patch*, March 21, 2018.

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31. "Parkview Hospital Emergency Department Expansion," Tilden-Coil Constructors, accessed August 2020.

32. "Redlands Community Hospital Completes Phase One of Emergency Department Expansion," *Inland Empire Community News*, January 28, 2019.

33. Meeting presentation (PDF), America's Physician Groups (APG) and Inland Empire Health Plan (IEHP), March 25, 2019.

34. 2018 data from *Ask*CHIS, UCLA Center for Health Policy Research, accessed August 1, 2020.

35. For additional information on the BHICCI, see Todd P. Gilmer et al., "Evaluation of the Behavioral Health Integration and Complex Care Initiative in Medi-Cal," *Health Affairs* 37, no. 9 (September 2018). 1442–9

36. 2018 data from AskCHIS, UCLA Center for Health Policy Research, accessed August 1, 2020.

37. 2018 data from the US Bureau of Labor Statistics, accessed November 11, 2020, show that the average annual salary across family medicine, internal medicine, and pediatrics in the Riverside–San Bernardino–Ontario area was $250,617, compared with $172,450 in the Los Angeles–Long Beach–Anaheim area and $239,493 in the San Diego area.

38. *Program Description — Provider Network Expansion Fund* (PDF), Inland Empire Health Plan, May 2019.

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41. "Scholarship Opportunities," University of California, Riverside School of Medicine, accessed August 2020.

42. Program brochure (PDF), California University of Science and Medicine, accessed August 2020.

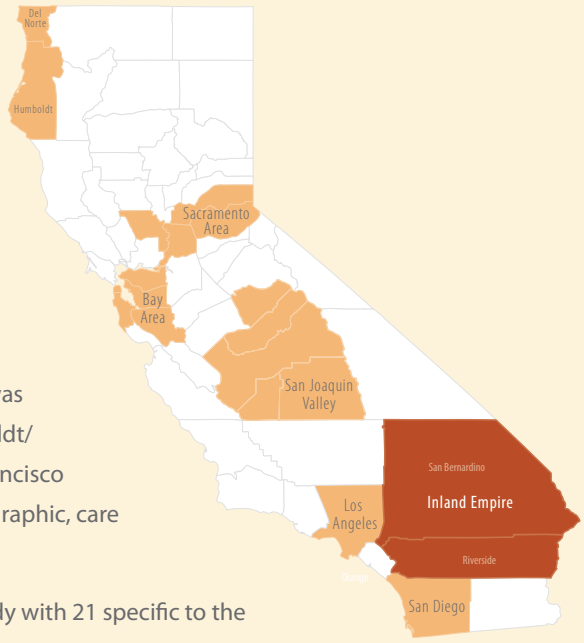
43. *Welcome to the KGI School of Medicine* (PDF), Keck Graduate Institute School of Medicine, accessed August 2020.

44. Memorandum, "Acceptance of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) Funding, Budget Establishment, and Administration, All Districts," Executive Office of County of Riverside, May 19, 2020.

45. "Blue Shield of California Offers Financial Support to Healthcare Providers in Response to COVID-19 Crisis," *PR Newswire*, April 6, 2020.

Background on Regional Markets Study: Inland Empire

Between January and August 2020, researchers from the Blue Sky Consulting Group conducted interviews with health care leaders in Riverside and San Bernardino Counties in the Inland Empire region of 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 fourth round of the study; the first set of regional reports was released in 2009. This is the first time the Humboldt/Del Norte region was included in the study. The seven markets included in the project — Humboldt/Del Norte, Inland Empire, Los Angeles, Sacramento Area, San Diego, San Francisco Bay Area, and the San Joaquin Valley — reflect a range of economic, demographic, care delivery, and financing conditions in California.

Blue Sky Consulting Group interviewed nearly 200 respondents for this study with 21 specific to the Inland Empire market. 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. The onset of the COVID-19 pandemic occurred as the research and data collection for the regional market study reports were already underway. While the authors sought to incorporate information about the early stages of the pandemic into the findings, the focus of the reports remains the structure and characteristics of the health care landscape in each of the studied regions.

► VISIT OUR WEBSITE FOR THE ENTIRE **ALMANAC REGIONAL MARKETS SERIES**.

ABOUT THE AUTHORS

Matthew Newman, MPP, is principal and co-founder of Blue Sky. James Paci, JD, MPP, is a policy analyst with **Blue Sky Consulting Group**, a firm that helps government agencies, nonprofit organizations, foundations, and private-sector clients tackle complex policy issues with nonpartisan analytical tools and methods.

ACKNOWLEDGMENTS

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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.

EXHIBIT “2”

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA

In re BORREGO COMMUNITY HEALTH FOUNDATION, a California nonprofit public benefit corporation, Debtor and Debtor in Possession.	Case No. 22-02384-LT11 Chapter 11 Case
BORREGO COMMUNITY HEALTH FOUNDATION, a California nonprofit public benefit corporation, Plaintiff, v. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Defendant.	Adv. Pro. No. No. 22-90056-LT **SUPPLEMENTAL DECLARATION OF JACOB NATHAN RUBIN, PATIENT CARE OMBUDSMAN, IN SUPPORT OF EMERGENCY MOTION: (I) TO ENFORCE THE AUTOMATIC STAY PURSUANT TO 11 U.S.C. § 362; OR, ALTERNATIVELY (II) FOR TEMPORARY RESTRAINING ORDER [Docket Nos. 3, 7]**

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SUPPLEMENTAL DECLARATION OF DR. JACOB N. RUBIN

I, Dr. Jacob N. Rubin, M.D., hereby state and declare as follows:

1. My name is Jacob Nathan Rubin, and I am the Patient Care Ombudsman (the "PCO") appointed in the above-captioned bankruptcy case (the "Case") of Borrego Community Health Foundation (the "Debtor") [Bankr. Docket No. 25] pursuant to 11 U.S.C. § 333(b).

2. As PCO, my duties include independently monitoring the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians and to provide reports to the Court if I determine that patient care is declining significantly or is otherwise being materially compromised. 11 U.S.C. §§ 333(b)(1) and (3).

3. I submit this Declaration in furtherance of my duties as PCO and in support of the Debtor's *Emergency Motion: (I) To Enforce The Automatic Stay Pursuant To 11 U.S.C. § 362; Or, Alternatively (II) For Temporary Restraining Order* [Docket No. 3] as supplemented by that *Ex Parte Application Supplementing Emergency Motion: (I) To Enforce The Automatic Stay Pursuant To 11 U.S.C. § 362; Or, Alternatively (II) For Temporary Restraining Order* [Docket No. 10] (the "Application" together with Docket No. 3 and as supplemented, the "Motion"), as a supplement to my *Declaration of Doctor Jacob Rubin* already filed in support of the Motion [Docket No. 4], and in support of this Court entering the order attached as Exhibit A to the Application as soon as possible.

4. In making this Declaration, I rely on my experience as a medical doctor licensed by the State of California and in hospital operations and management spanning 30 years.

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September 27, 28 and 29 Visits and Ongoing Danger to Patients, including Pregnant Patients

5. With my consultant Dr. Tim Stacy, I visited the Debtor's facilities on September 27 and 28, 2022. During these visits, I learned that Inland Empire Health Plan has been transferring and continues to transfer patients to other provides and/or hospitals without notice to, or knowledge of, such patients.

6. Other providers and hospitals may be as far as 1.5 to 2 hours away from the patients (for example, I visited a clinic where many patients access the facilities ***by foot***), and, as a result, patients, many of whom subsist on a low-income, do not have the means to obtain transport themselves to the new providers. Of particular concern are the pregnant patients that rely on the Debtor and its facilities. For example, Desert Regional Medical Center, which is the primary source for deliveries for pregnant women and in which approximately 60 deliveries occur per month (many high risk), has been changed to providers that are 1.5 to 2 hours away. These pregnant patients simply cannot make these changes without serious risk to their health and that of their unborn children. These patients are in urgent need of medication and continuity of healthcare, but are not able to receive it. I have come to this conclusion by my review of patient insurance cards and discussions with the Debtor's women's health clinic.

September 28 Visit and Ongoing Danger to Hepatitis C and HIV/AIDS Patients

7. On September 29, 2022, I and Dr. Stacy visited Stonewall Medical Center, which focuses on hepatitis C and HIV/AIDS patients, and transgender health. I am informed and believe that it provides care to more than 1000 patients. In my professional opinion, there are no acceptable alternatives to the treatment provided by this clinic. Because of the notification from DHCS to the health plans whose patients are assigned to this clinic, I am informed and believe those health plans are transferring patients to remote and insufficient alternative care sites. These patients will suffer immediate and irreparable harm if DHCS does not instruct the health plans

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to return those patients to Debtor's care immediately. This is a true emergency that cannot wait a day.

8. I also engaged in discussions with the physician and providers yesterday for this clinic, wherein I learned that the majority of the served HIV patients are elderly. The burden placed on these patients to find new providers and traveling long distances in hopes of getting their medication timely is unreasonable and inhumane. Without timely medication, HIV viral loads increase, CD4 counts reduce that rapidly increase the conversion risk to AIDS. This will lead to the transmission of the virus to partners and increase in community incidence rates creating a public health hazard.

9. Additionally, removing access to the 340-B pharmacy (carrying medicines that are not available at most commercial pharmacies such as CVS and Walgreens), on the premises of the HIV clinic and only accessible to the clinic's patients, may make the critical medications unobtainable. The standard regimen is called HARRT (Highly Active Antiretroviral Therapy). The name speaks for itself. Any interruption to the medical treatment, even for just a few days, can lead to drug resistance given the resilience of the virus.

Conclusion

10. As the PCO, I am the "boots on the ground" and I have witnessed the potential for serious, life-threatening deficiencies in the past 72 hours that will occur if unchecked. **These deficiencies are the result of the health plans moving patients based upon representations by DHCS to the health plans.** Despite the foregoing, the clinics are seeing the patients who have been disenrolled because of their concern, compassion and long-term relationships with the patients and their families.

11. In contrast, DHCS' total disregard for the patients and the providers is shocking. I cannot discern why DHCS, no matter what kind of financial facts it believes exist, has taken actions that are causing health plans to move patients from an organization that is providing healthcare consistent with the standard of care and with no reasonable alternatives for the patients.

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12. I can represent that based on my visits and my three decades of experience, including as PCO in other cases, that the Debtor is currently serving the intended community when no one else can. The patients are well cared for. The providers are dedicated and compassionate. The clinics are state of the art and spotless. The consequences of a shut down or material drawback of services is devastating. To protect the patients, DHCS must direct the health plans to re-assign the patients back to the Debtor and DHCS must continue to pay the Debtor for healthcare provided by the Debtor to its patients.

Affirmation of Statements in Maizel

13. I also affirm the statements that Samuel R. Maizel attributed to me in his *Supplemental Declaration* in support of the Motion [Docket No. 10 at pp. 7-31] (the Supplemental Maizel Decl.) in paragraph 9.

14. I **have:**

> *[G]reat concern with regard to patient care because Inland Empire Health Plan, and possibly other plans, is reassigning patients from the Debtor to other providers, often apparently without notice to the patients, and telling the Debtor's representatives that they are doing this because of instructions from DHCS. The net result is that patients show up for appointments, and when intake tries to verify their coverage (which requires verifying that they are a patient assigned by the health plan to the Debtor) they are being told the patient is no longer assigned to the Debtor. In some cases the Doctors, unwilling to abandon longstanding patients, are treating them anyway. This is not a viable solution because (a) the Debtor will be effectively providing free care, and (b) the Doctor cannot refer the patient to a specialist, because the health plan will not accept that referral. In other cases the patients are being turned away, sometimes with no idea of where to go for medical care or having been reassigned to a doctor too far away for them to get there.*

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15. All of the statements attributed to me in paragraph 9 of the Supplemental Maizel Decl. are accurate.

I declare under penalty of perjury that, to the best of my knowledge and after reasonable inquiry, the foregoing is true and correct.

Executed this 29th day of September 2022, at Los Angeles, California.

Dr. Jacob R. Rubin

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is: 2818 La Cienega Avenue, Los Angeles, CA 90034.

A true and correct copy of the foregoing document entitled **FIRST REPORT OF PATIENT CARE OMBUDSMAN, JACOB NATHAN RUBIN, MD, FACC, PURSUANT TO 11 U.S.C. § 333(b)(2)** will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF): Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On **November 11, 2022**, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

- **Christine E. Baur christine@baurbklaw.com, admin@baurbklaw.com**
- **Daren Brinkman dbrinkman@brinkmanlaw.com, office@brinkmanlaw.com;7764052420@filings.docketbird.com**
- **Shawn Christianson schristianson@buchalter.com, cmcintire@buchalter.com**
- **Anthony Dutra adutra@hansonbridgett.com, SSingh@hansonbridgett.com**
- **Jeffrey Garfinkle jgarfinkle@buchalter.com, lverstegen@buchalter.com;docket@buchalter.com**
- **David B. Golubchik dbg@lnbyg.com, dbg@ecf.inforuptcy.com**
- **Michael I. Gottfried mgottfried@elkinskalt.com, rzur@elkinskalt.com,cavila@elkinskalt.com,myuen@elkinskalt.com,1648609420@filings.docketbird.com**
- **Bernard M. Hansen bernardmhansen@sbcglobal.net**
- **Teddy Kapur tkapur@pszjlaw.com;jpomerantz@pszjlaw.com;sgolden@pszjlaw.com**
- **Dean T. Kirby dkirby@kirbymac.com, jwilson@kirbymac.com;rrobinson@kirbymac.com;Jacquelyn@ecf.inforuptcy.com**
- **Tania M. Moyron tania.moyron@dentons.com, derry.kalve@dentons.com;DOCKET.GENERAL.LIT.LOS@dentons.com**
- **David Ortiz david.a.ortiz@usdoj.gov, USTP.REGION15@USDOJ.GOV;tiffany.l.carroll@usdoj.gov;abram.s.feuerstein@usdoj.gov**
- **Jeffrey N. Pomerantz jpomerantz@pszjlaw.com;tkapur@pszjlaw.com;sgolden@pszjlaw.com, scho@pszjlaw.com**
- **Michael B. Reynolds mreynolds@swlaw.com, kcollins@swlaw.com**
- **Olivia Scott olivia.scott3@bclplaw.com, theresa.macaulay@bclplaw.com**
- **Andrew B. Still astill@swlaw.com, kcollins@swlaw.com**
- **Kelly Ann Mai Khanh Tran kelly@smalllawcorp.com, stefanny@smalllawcorp.com**
- **United States Trustee ustp.region15@usdoj.gov**
- **Kenneth K. Wang kenneth.wang@doj.ca.gov**

2. SERVED BY UNITED STATES MAIL: On **November 11, 2022**, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows. Listing the judge here constitutes a declaration that mailing to the judge will be completed no later than 24 hours after the document is filed.

None.

☐ *Service information continued on attached page*

3. SERVED BY PERSONAL DELIVERY, OVERNIGHT MAIL, FACSIMILE TRANSMISSION OR EMAIL (state method for each person or entity served): Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **November 11, 2022**, I served the following persons and/or entities by personal delivery, overnight mail service, or (for those who consented in writing to such service method), by facsimile transmission and/or email as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

None.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

November 11, 2022	Stephanie Reichert	*/s/ Stephanie Reichert*
Date	*Type Name*	*Signature*