HEALTH CENTER® PARTNERS of Southern California

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March 20, 2026

San Diego County Board of Supervisors
County Administration Center
1600 Pacific Highway, Rm 335
San Diego, CA, 92101

Re: Item #27: Return Back on Options for Establishing a Safety Net Bridge Program to Address Anticipated Gaps in Services for Residents Disenrolled from Benefit Programs and Authorize Implementation Planning for a Safety Net Bridge Program Pilot

To San Diego County Board of Supervisors:

On behalf of Health Center Partners of Southern California (HCP) and it's 17 members of federally qualified health centers (FQHCs), and Tribal and Urban Indian health centers, who collectively provide care to almost 600,000 San Diego County residents each year, please accept this letter on Agenda Item #27.

Our member organizations are established, trusted points of care where patients receive primary care, behavioral health services, dental care, maternal health services, and other essential clinical care. Together, they serve patients regardless of insurance status and have longstanding relationships with the communities most affected by coverage disruptions.

Thank you for the time and thoughtful deliberation you are providing to the proposed Safety Net Bridge Program. I appreciate the opportunity to provide input on the Board's March 25, 2026 agenda item #27, *Establishing a Safety Net Bridge Program Pilot*.

HCP member organizations strongly support Option 1(b) and Option 6 as the most cost effective and feasible approaches.

Based on the County's own feasibility, cost, and implementation analysis, HCP strongly supports:

- **Option 1(b): Telehealth Transitional Access Clinic delivered through Community Health Centers**
- **Option 6: Contract with Community Health Centers for Medical Care and Linkage to Social Services**

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The County's Feasibility Analysis (Attachment A) demonstrates that contracting and partnering with **CHCs is the most cost-effective approach** across all the options evaluated. The Feasibility Analysis estimates costs to serve 17 patients in a 4-hour clinic. The ongoing costs when contracting **with a health center range from $3,536 to $6,714**. In contrast, **County operated models carry substantially higher estimated ongoing costs, ranging from $13,867 to $22,693 per four-hour clinic**. Furthermore, the County's analysis also notes that scaling Option 6 has a relatively short implementation timeline compared to county-operated options. We are already seeing drops in enrollment, and the most expedient option will keep the most people connected to care.

Keep patients connected to their medical homes

Health centers already function as **Primary Care Medical Homes** for a large share of Medi Cal managed care members who are assigned to a clinic site and care team. FQHCs are designed to serve as the backbone of the safety net. FQHC sites are in medically underserved areas by federal design, provide care regardless of ability to pay, and integrate enabling services that help patients navigate coverage and care.

Many people at risk of losing coverage will be temporarily disenrolled due to administrative barriers, not loss of need. Creating parallel access points or new clinic structures risks confusing patients, fragmenting care, and delaying access for those with chronic conditions who need ongoing primary care and medications.

Primary care workforce constraints should drive investments in existing capacity

Workforce capacity and implementation feasibility are core constraints according to the County's analysis. A reliance on volunteer clinical staffing jeopardizes the sustainability of county-run clinics and undercounts the national shortage of primary care providers. Health centers are strategically located in underserved communities and already operate team-based models that maximize scarce primary care capacity, including same day telehealth and in person visits, extended hours in many locations, and integrated patient navigation. Rather than building a new delivery system, Options 1(b) and 6 scale what already works with a limited workforce.

Pharmacy and medication access strongly favor a health center contracted model

The County Feasibility Analysis makes clear that one of the strongest advantages of partnering with community health centers is immediate access to **340B drug pricing**, which dramatically lowers the cost of prescription medications for uninsured and underinsured patients. Using the County's own case profiles and cost methodology, the Feasibility Analysis estimates an average monthly medication cost per patient of **$90.61 when 340B pricing is available**, compared to **$369.17 without 340B pricing**, a difference of more than 70 percent for the same sample patients.

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Health centers are already designated covered entities under the 340B program and have established pharmacy relationships that allow medications to be integrated seamlessly with primary care and follow-up. In contrast, Attachment A outlines that the County does not currently operate a licensed retail pharmacy open to the public at Public Health Centers, and that County operated Transitional Access Clinics would require new pharmacy licensing, infrastructure, and staffing to provide same day medications.

The Feasibility Analysis further describes the **significant operational and timeline challenges the County would face if it sought to pursue FQHC look-a-like designation** solely to access 340B pricing. This process would require establishing new governance, infrastructure, policies, and compliance with extensive and evolving HRSA program requirements, followed by a multi-step review and site visit process. These requirements underscore that creating a new County operated FQHC look-a-like model is neither a timely nor practical strategy for securing 340B savings in the near term, compared to leveraging existing health center capacity that already delivers cost effective medications today.

HR1 created an environment full of threats to the health safety net

Across California, recent events underscore how quickly safety-net capacity can be destabilized when public systems face fiscal and policy shocks. In Los Angeles County, budget reductions led the Department of Public Health to end clinical services at multiple public health clinic sites, thereby shrinking the number of full-service public health clinics and pushing more patients toward an already-stretched community provider network.

HR1 intensifies pressures by increasing the risk of coverage churn and administrative disenrollment, driving more uninsured visits, and shifting uncompensated care and enrollment work onto safety-net providers. When more residents lose Medi-Cal for procedural reasons, clinics and hospitals see higher volumes of delayed care, more complex health needs, and greater operational burden to support re-enrollment, all without a commensurate increase in sustainable funding. Without an effective bridge strategy, these pressures ultimately increase uncompensated care, emergency department utilization, and fiscal exposure for counties. San Diego County can mitigate these risks by engaging community health centers as core delivery partners rather than creating duplicative systems that take longer and cost more to stand up.

San Diego County can avoid the fragmentation and disruption seen elsewhere by thoughtfully engaging and partnering with FQHCs and other community providers as implementation planning moves forward. Not one system can do this alone. It is essential that each part of the health care ecosystem, including County programs like self- sufficiency and public health, managed care plans, hospitals, community-based organizations, and FQHCs optimizes its strengths so that together we can reach all San Diego County residents, particularly those most likely to be impacted by HR1.

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- Co-design the Safety Net Bridge Program with FQHCs and Tribal/Urban Indian health centers to preserve continuity with existing medical homes.
- Invest in enrollment assistance, patient navigation, and data-sharing workflows that reduce churn and keep patients connected to care during coverage gaps.
- Align access strategies with clinic capacity and hours (including telehealth) to avoid duplicating services and to direct residents to the right site of care the first time.
- Ensure any contracted approach includes clear coverage expectations and sustainable financing so safety-net partners are not asked to absorb new costs as an unfunded mandate.

Alignment with County Medical Services and County legal responsibilities

The Safety Net Bridge framework will need to coordinate and align with the Board directed review of **County Medical Services** and Board Policy A-67 on primary care services. We strongly support aligning Safety Net Bridge planning with these reforms so that the County strengthens a single coherent pathway for medically indigent adults and those experiencing temporary coverage gaps, rather than creating new parallel structures.

As planning advances, negotiations for Option 6 should include clear discussions of coverage responsibilities and should not create an unfunded mandate for community health centers.

Patients at risk are our health center patients

The Feasibility Analysis explains approximately 314,000 San Diego County Medi-Cal recipients will be subject to new requirements and approximately 100,000 of those residents are anticipated to be at-risk of losing healthcare coverage. These individuals are not hypothetical; they are patients who currently receive their care at community health centers. Health centers serve the majority of Medi-Cal patients in the county and will continue to serve these patients regardless of their coverage status, while simultaneously working to get them re-enrolled.

A partnership approach will reach patients faster and avoid duplication

HCP and our member health centers stand ready to work with the County and managed care plans on practical steps that protect continuity of care, including:

- Targeted outreach to individuals at risk of losing Medi Cal coverage
- Clear education on where each person's medical home is located and how to schedule care during a coverage gap

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- Warm handoffs and referral pathways through existing navigation and access points, including 211 and networks of CBO partners.
- Coordinated enrollment and renewal assistance that builds on existing County and clinic eligibility workflows through the CBO warmline.

We urge the County to avoid duplicating efforts already underway in the health care ecosystem. If the County believes there are coverage or access gaps, we ask that the County identify the barrier and partner with health centers to solve it. Health centers share the County's goal to fill gaps quickly and equitably.

For these reasons, we respectfully urge the Board to advance **Options 1(b) and 6** and to direct staff to move forward with implementation planning that positions community health centers as the primary delivery partners for the Safety Net Bridge Program pilot. Doing so will allow the County to reach residents more quickly, avoid unnecessary duplication, preserve continuity of care, and manage fiscal and operational risk.

Health centers have long served as trusted partners to the County in delivering primary care and protecting the safety net. We remain ready and willing to meet this moment and to ensure continuity of primary care and medication access in a fiscally responsible and patient-centered way.

Thank you again for your leadership and thoughtful consideration.

In partnership,

Signed by:
Sparkle Barnes
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Sparkle Barnes
President and CEO
Health Center Partners of Southern California