

SAFETY NET BRIDGE FEASIBILITY ANALYSIS

*Exploring Options to Address Anticipated Gaps in Services
for Residents Disenrolled from Benefit Programs*

March 24, 2026



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Executive Summary

The Safety Net Bridge Feasibility Analysis Report responds to the November 4, 2025 (12) direction from the San Diego County Board of Supervisors (Board) to explore establishing a Safety Net Bridge program. The purpose of the program is to provide no-cost, co-located primary care, same-day prescription medications, and same-day fresh food distribution to residents experiencing gaps in services due to impending federal and State policy changes in Medi-Cal and CalFresh.

Under new federal and State rules, significant portions of the county's population may face reduced or lost Medi-Cal and CalFresh benefits leading to a growing gap in the areas of access to food, continuity of primary care, and access to prescription medication. Many residents at risk of losing benefits also live with chronic health conditions that require ongoing management. Existing County resources, including Public Health Centers and pharmacies, do not currently provide primary care, limiting their ability to serve as a fully integrated safety net without new investments or partnerships.

In response to the Board's direction to explore options to establish a Safety Net Bridge Program, County staff assessed the anticipated impacts of new eligibility requirements, analyzed existing County and community resources, gathered extensive community input, and developed six potential Transitional Access Clinic options to support residents disenrolled from benefit programs. This work builds on a broader County strategy focused on proactive customer service, advocacy, technology solutions, workforce readiness, and strong community partnerships.

County staff developed six Transitional Access Clinic options that vary in scope, cost, infrastructure requirements, and implementation timeline. All options deliver primary care, assistance with reenrolling in benefits, and access to medications and food. The six options include:

- 1. Telehealth Transitional Access Clinic**

A low-barrier, scalable virtual model leveraging County volunteers or Community Health Centers. It has minimal facility requirements but requires investment in telehealth platforms and pharmacy strategies.

- 2. Expand Capacity at Existing Free Clinics**

Builds on two existing free clinic networks to add clinic sites, medication support, and eligibility assistance.

- 3. Mobile Medical Units at Live Well Centers**

Deploys mobile clinics at County Live Well Centers. Timelines are shorter than brick-and-mortar clinics but require pharmacy solutions and staffing.

4. **County-Operated Transitional Access Clinics in Live Well Centers**
Establishes permanent primary care clinics within existing County facilities. This option requires the most significant infrastructure, licensing, and information technology (IT) investments.
5. **Community Health Fairs**
Provides flexible, geographically targeted services through mobile medical units in partnership with community health centers. This option can be deployed quickly and supports “meeting people where they are.”
6. **Contract with Community Health Centers for Medical Care and Linkage to Social Services**
Subsidizes visits, medication, and food through existing clinic contracts (similar to the County Medical Services model), enabling residents to remain with their established primary care providers.

Each option includes estimated cost ranges, workforce and infrastructure needs, and considerations related to leveraging Section 340-B drug pricing, either through partnerships or by pursuing Federally Qualified Health Center (FQHC) look-alike designation.

Food access strategies span cold-storage expansion, refrigerated transportation, partnerships with local food banks and hubs, and other components aligned with the Food Justice Community Action Plan. These efforts will support distribution of fresh food through any of the clinic models.

County staff recommend a **phased approach**, beginning with a pilot in a geographically high-need area where Medi-Cal disenrollment is most likely. Pilot findings would inform expansion and refinement of Transition Access Clinic models. Longer-term decisions, including potential pursuit of FQHC look-alike status, infrastructure investments, and partnership structures, will depend on available funding, policy guidance, and identified community needs.

Background

On November 4, 2025 (12), the San Diego County Board of Supervisors (Board) directed the Chief Administrative Officer (CAO) to explore opportunities to establish a Safety Net Bridge program that would provide no-cost primary care medical services co-located with social services, same-day access to prescription medication free-of-charge, and same-day access to fresh food to address anticipated gaps in services due to barriers created by shifts in federal policy.

In partnership with the Board office that initiated this action, County staff have assessed potential gaps in service as a result of changes to eligibility programs, mapped out the current landscape and existing resources for providing Transitional Access Clinic services, and generated options for the Board's consideration to prepare for the potential impacts of residents losing access to food assistance and primary care.

On February 5, 2026, staff provided a preliminary feasibility analysis as a memorandum to the Board that described six potential options for scalable primary care, medication, and eligibility services: 1) Telehealth Transitional Access Clinic; 2) Expand Capacity at Existing Free Clinic(s); 3) Mobile Medical Units at County Live Well Centers; 4) County-Operated Transitional Access Clinic(s) at County Live Well Centers; 5) Community Health Fairs; and 6) Contract with Community Health Centers. A separate description of food access resources and a menu of food access options was included that can be combined with the different clinic models.

These options provided align with a larger coordinated County strategy to strengthen the safety net and assist eligible persons to remain enrolled amidst State and federal policy changes. This work is guided by five primary areas of focus: 1) Proactive Customer Service and Communication; 2) Statewide Engagement and Advocacy; 3) Technology and Data Solutions; 4) Workforce Capacity and Administrative Readiness; and 5) Cross-Sector and Community Partnerships.

Landscape Analysis

Assessment of Existing County Resources

Medical Care:

The County Live Well Centers are community hubs where residents can access County mandated health and social services in one convenient location. The Live Well Centers include designated clinical space to serve as Public Health Centers (PHCs) offering free or low-cost access to vaccines and specialty health services including immunization, tuberculosis, and sexual health services to meet local health jurisdiction responsibilities under Health & Safety Code and Title 17 of the California Code of Regulations. Each month, the six County PHCs provide a combined average of 1,850 core public health services to clients at these sites. Currently, the County does not provide primary care services at its PHCs.

Pharmacy Services:

The County operates licensed pharmacies in the San Diego County Psychiatric Hospital (SDCPH), the Edgemoor Skilled Nursing Facility, a centralized pharmacy which supports Behavioral Health outpatient clinics and Public Health Centers, and a Mobile Pharmacy Unit (MPU) that supports naloxone distribution, vaccinations and education at community events. Last year, the MPU serviced 145 events and 3,671 clients. Currently, the County does not have a licensed retail pharmacy at any PHC, nor does it operate a pharmacy open to the public. The County leverages multi-state purchasing agreements with pharmaceutical suppliers to ensure fair and competitive pricing on medications.

Section 340B(a)(4) of the federal Public Health Service Act allows eligible healthcare centers to purchase medications at substantially reduced prices to serve low-income and uninsured patients. Organizations eligible to receive 340B designation, known as covered entities, include federally qualified health centers (FQHCs) and health center program look-alikes; Tribal and urban Indian health centers; Children's hospitals, Disproportionate share hospitals (DSH); Ryan White HIV/AIDS program grantees, and specialized clinics such as sexually transmitted disease clinics and tuberculosis clinics. The County's specialized clinics are authorized under Section 340B as a covered entity; however, the authorization only covers medications used to treat tuberculosis and sexually transmitted infections prescribed in PHCs.

To participate in the 340B drug pricing program for primary care services, the County would need to be designated a "covered entity" by Health Resources & Services Administration (HRSA). Options include partnering with a DSH outpatient clinic or a FQHC. Alternatively, the County could seek designation from HRSA as a health center

program look-alike, informally known as a “FQHC look-alike.” Similar to FQHCs, FQHC look-alikes are community-based, non-profit, or public clinics that meet HRSA requirements for an FQHC but do not receive federal funding under Section 330 of the Public Health Service Act. Specifically, FQHC look-alikes provide comprehensive primary and preventive care services to an underserved and/or vulnerable population, serve all patients regardless of ability to pay using a sliding fee scale, and operate under a governing board of whom the majority are patients. The County could apply to HRSA for FQHC look-alike designation, upon establishing fiscal and operational structures and a governing body as above. The application process, which could take several months, includes a preliminary review by HRSA, followed by an operational site visit to ensure compliance with 18 HRSA program requirements and more than 90 elements for designation to be considered. Designation as an FQHC look-alike would allow the County to leverage 340-B reduced drug pricing for primary care medications as analyzed for the purposes of this memorandum.

In order to receive FQHC look-alike designation by HRSA:

1. Develop infrastructure and location for each proposed site.
2. Confirm the location(s) meets HRSA recommendations, including that the proposed site is not located within 1 mile of a current FQHC or look alike site, or more than 15 miles from the next closest if we propose multiple sites.
3. Submit an application through HRSA. This application includes developing and submitting for review:
 - a. all policies and procedures for personnel, fiscal, internal control, billing and collections, Quality Improvement, governance documents, staffing profile, income analysis (projected income by payor),
 - b. list of services,
 - c. description of FQHC look-alike board members,
 - d. list of FQHC look-alike contracts, and
 - e. names of FQHC look-alike leadership staff
4. HRSA would then complete a preliminary review, and if approved, schedule a site visit within 90 days of the review.
5. HRSA would complete an onsite compliance review within 60-75 days of the onsite visit, to which the County must respond within 30 days with all additional information requested.
6. The final issuance of look-alike designation (or disapproval) would occur within 30-45 days.

Continuing Medical Education:

The County has an active program that provides continuing education credits at no cost to community clinicians who participate in monthly Healthcare Professional Telebriefings.

Eligibility Services:

County eligibility workers help people enroll in services like Medi-Cal and CalFresh in-person, online, and over the phone. In-person services occur at Live Well Centers and Family Resource Centers, as well as “outstations” at community-based locations or events with the Live Well Mobile Office. Over the past several years, County Self Sufficiency Services (SSS) staff have intentionally shifted towards phone and online service through the California Statewide Automated Welfare System (CalSAWS) application portal to reduce barriers for customer access, leading the State in automation innovation and system enhancements, and customer service innovations to enroll people more quickly and accurately in services.

Specific resources in place to reduce barriers for individuals with a pending application include a dedicated “Access Community Based Organization (CBO)” telephone line for CBOs, including for community health centers, to connect with SSS staff. Additionally, community health centers typically employ enrollment specialists to assist clients with the County application process for Medi-Cal and other public benefit programs and connect them to other social supports.

Assessment of Potential Gaps

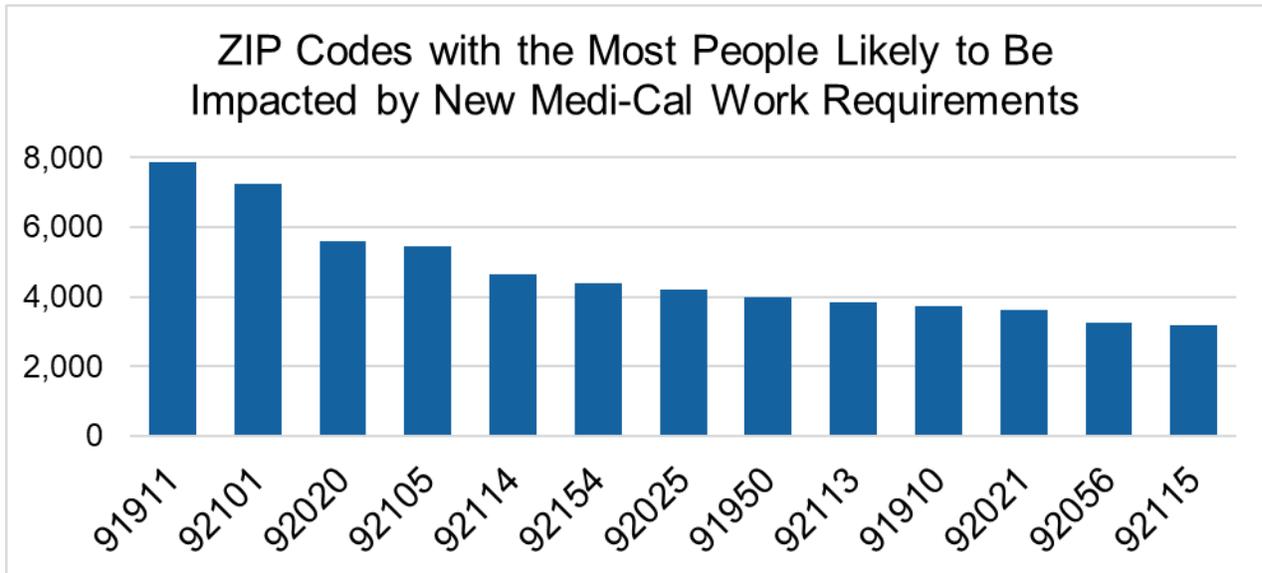
The following table delineates the estimated number of people in San Diego County who are potentially at risk of losing coverage as a result of new federal and State Medi-Cal and CalFresh eligibility requirements as of December 2025. Notably, these estimates are based on the limited policy guidance received to date from the State and federal government. Many Medi-Cal policy implementation details, such as frequency of work requirement verifications, required forms, eligible work and volunteer opportunities have not yet been received from the State or federal government.

Policy Change	Effective Date	Estimated Impacted Population
CalFresh Work Requirements for Able-Bodied Adults Without Dependents (ABAWD)	June 1, 2026	93,500
CalFresh prohibition for individuals with Unsatisfactory Immigration Status (UIS)	April 1, 2026	13,000
Full-scope Medi-Cal enrollment freeze for UIS	January 1, 2026	Unknown - applies to new applicants only
Full-scope Medi-Cal eligibility restricted for already-enrolled UIS	October 1, 2026	75,000
Medi-Cal Work Requirements	January 1, 2027	314,000
Medi-Cal Semi-Annual Redeterminations	January 1, 2027	130,000

Various agencies have produced different estimates for Medi-Cal impacts; for example, the California Budget and Policy Center (Budget Center) estimates that 176,000 to 269,000 San Diego County Medi-Cal recipients will be subject to the new requirements and therefore at risk of losing coverage once the policy is fully implemented. Using the methodology from the California Department of Health Care Services, it is anticipated that approximately 100,000 of the 314,000 San Diego County Medi-Cal recipients subject to the new requirements will be at risk of losing coverage.

Upon the loss of CalFresh and Medi-Cal benefits, even temporarily as documentation is being submitted, impacted individuals are likely to need immediate access to food resources. Primary care services and prescription medication are likely to be needed by those with physical health conditions, representing 32% of Medicaid enrollees ages 27-49 and 61% of enrollees ages 50-64.¹ The five most frequent physical diagnoses of non-elderly adult Medicaid enrollees are high blood pressure, high cholesterol, obesity, diabetes, and arthritis.

As part of the feasibility analysis for the Safety Net Bridge program, staff analyzed available Medi-Cal data to identify the ZIP codes with the most people likely to be impacted by new Medi-Cal work requirements, which are (in descending order): 91911, 92101, 92020, 92105, 92114, 92154, 92025, 91950, 92113, 91910, 92021, 92056, and 92115. This encapsulates each of the ZIP codes of San Diego County with more than 3,000 Medi-Cal recipients who are adults aged **40-64 years old without dependents**.

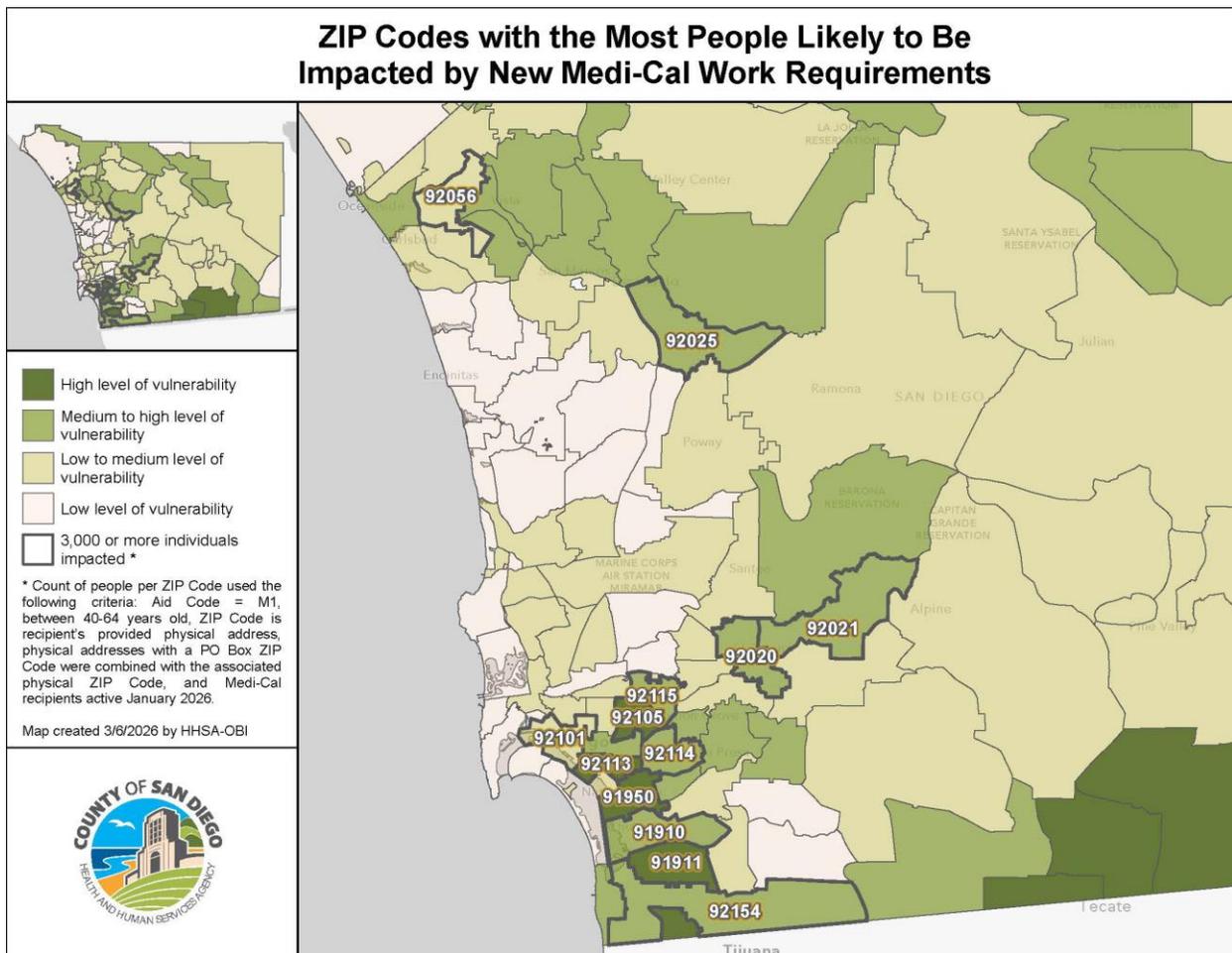


Note: Count of people per ZIP code used the following criteria: Aid Code = M1, between 40-64 years old, and ZIP code is recipient's provided physical address. Recipients using a Family Resource Center (FRC) as their address (primarily

¹ [5 Key Facts About Medicaid Coverage for Adults with Chronic Conditions | KFF](#)

people experiencing homelessness) were combined with the associated physical ZIP code of that FRC. Medi-Cal recipients active January 2026.
 Source: County of San Diego, Health and Human Services Agency, Self Sufficiency Services. CalSAWS. February 27, 2026.

The following map is a visual representation of the 13 ZIP codes to illustrate the geographic distribution of the areas where people are likely to be highly impacted by federal changes. The Center for Disease Control and Prevention’s Social Vulnerability Index (SVI) is included in the map to show which areas of San Diego County have demographic and socioeconomic factors that adversely affect communities. Of note, two ZIP codes (92056 and 92101) which met the criteria used to identify the areas with the most people likely to be impacted by new Medi-Cal work requirements are in the low to medium level of vulnerability based on the SVI. SVI does not incorporate local counts of individuals experiencing homelessness, and these ZIP codes include Family Resource Centers- which can be used by people experiencing homelessness as their address for eligibility services.



Primary Care Transitional Access Clinic Options

Based on analysis of the current landscape² and expertise and input from community partners, County staff crafted the following six options for potential implementation of Transitional Access Primary Care Clinics to address gaps due to federal shifts, pending identification of sustainable funding. Each option is designed with a one-stop-shop approach addressing primary care, reenrollment in Medi-Cal or other benefits, and access to prescription medications and nutritious food. With the acknowledgement that different communities and different geographic areas of the county have unique resources and distinct needs, a variety of approaches could be utilized by offering more than one option to serve each community.

County staff built upon 41 listening sessions held in 2025 with 94 community health and social care providers, consumers and advocates and created additional opportunities to gather input from community partners to inform the Transitional Access Clinic options described below. Opportunities included in-person visits to observe delivery of primary care services, including community health fairs, federally qualified health centers, and mobile medical units; in-person conversations with Medi-Cal members (304 adults attended Community events, which were held in every supervisorial district); participation in curated conversations led by the Board office initiating this action; and multiple conversations and meetings with clinical and social care leaders throughout the region, include those with clinic directors to estimate staffing and productivity standards.

Given the significant uncertainty of the impacts of federal policy changes, County staff recommend a phased approach beginning with a pilot to assess usage in a geographical area with a large potential for decreased Medi-Cal enrollment rates, recognizing that some of the individuals at risk of losing Medi-Cal coverage have established continuity of care with a primary care medical home, and other will need assistance finding a health provider. Implementation will also depend on identification of sustainable funding. Existing community health center services explored through this initiative utilize a variety of funding sources. Staff will continue to explore availability of funding sources to support implementation of a Transitional Access Clinic.

The following table provides a summary of the Primary Care Transitional Access Clinic Options explored in this feasibility analysis report. Each option has anticipated one-time implementation costs and ongoing operational costs developed using the methodology described below. Considerations for one-time initiation costs are included with an estimated cost range of each option, where available. Costs should be understood as planning estimates and are expected to vary based on patient volume, diagnoses, needs, utilization, and duration of coverage disruption. The widest range of cost estimates occur

² [Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses](#)

in the first five options presented, which includes the possibility for reduced pricing for prescription medications. Community Health Centers, the sole entity in Option 6, currently receive reduced medication pricing.

Summary of Primary Care Transitional Access Clinic Options

Transitional Access Clinic Option	Cost Range per 4-Hour Clinic	Implementation Timeline	Key Considerations
1. Telehealth Transitional Access Clinic	\$5,692 - \$22,693	~1 year (pilot)	Requires telehealth platform (\$250K one-time); IT integration; pharmacy licensing; clinician staffing
2. Expand Capacity at Existing Free Clinics	\$14,165 – \$16,680	6 months	Greatest opportunity in medication and food;
3. Mobile Medical Units at Live Well Centers	\$2,647 – \$18,185	County-Operated ~1 year	Less infrastructure investment than brick-and-mortar; pharmacy licensing needed
		Partnering with Community Health Center 3-6 months	
4. County-Operated Clinics at Live Well Centers	\$13,867 – \$17,094	Several years	Significant upfront facility modifications; licensing; IT integration
5. Mobile Medical Units at Community Health Fairs	\$12,883 – \$18,801	3–6 months	Minimal upfront cost; partnership-driven; continuity of care priority
6. Contract with Community Health Centers for Medical Care and Linkage to Social Services	\$3,536 – \$3,740	~1 year	Uses CMS model; minimal upfront cost; contract negotiation required

Cost Methodology

As a methodology to estimate ongoing costs, County staff developed a care model and applied it to each of the options below to create a similar basis for cost comparison. The model includes staffing, infrastructure, and supply costs to operate a four-hour Transitional Access Clinic. For the purposes of cost comparison, each four-hour clinic will serve approximately 17 patients, based on primary care clinic staffing and productivity metrics used by local Community Health Centers and other Community Based

Organizations. The model includes a direct service care team for a four-hour clinic consisting of the following, unless otherwise noted:

- Clinic staff – Two providers (Medical Doctor or Nurse Practitioner), one Staff Nurse, three Licensed Vocational Nurses, two Office Assistants
- Pharmacy staff – Pharmacist, Pharmacy Technician and Pharmacy Manager (partially dedicated) to serve as mandated Pharmacist-in-Charge
- Self-Sufficiency staff – Human Services Specialists
- Case Management – Two Community Health Workers or Patient Navigators

Indirect costs such as program coordination and oversight, medical supervision, training and compliance were added as applicable to develop a cost per four-hour clinic, which could be easily expanded based upon need and available resources. To the greatest extent possible, costs and timelines provided also account for planning and implementation of the following necessary infrastructure for each of the options that include a County-operated component:

- Information Technology: The Health and Human Services Agency (HHS) recently executed a contract for an electronic health record. HHS is currently in the early stages of implementation with the go-live date anticipated in late 2026. Although this critical infrastructure need is already in process and implementation is largely funded through the Epidemiology and Laboratory Capacity (ELC) grant, there would be one-time costs to develop workflows, integrations and training materials for a new primary care clinic service. The electronic health record will be the primary means to collect and analyze data on access to Safety Net Bridge services, in addition to data collected by County Self-Sufficiency Services.
- Policy & Procedures: Staffing resources to develop policies and procedures for new operational and clinical functions.
- Compliance & Licensing: Compliance with all applicable regulations and clinic licensing will depend on the option(s) selected.
- Pharmacy: In order to dispense same-day prescriptions to patients free of charge, each Transitional Access Clinic would need to have a fully licensed retail pharmacy, or delivery/mail agreements with a pharmacy. Licensing requirements of the California Board of Pharmacy include appropriate staffing, facilities (backup generator, HVAC specifications), etc.
- Human Resources: Recruiting, hiring, training and supervising staff and volunteers.

In order to create an accurate representation of costs associated with equipment, supplies and provision of no-cost prescription medication, clinical staff developed “client case profiles,” as realistic examples of patients served during a Transitional Access Clinic shift

to extrapolate an average medication cost per patient. The case profiles were based on published rates of Medicaid client health conditions and confirmed through conversations with local Medical Directors and physician leaders. This provided valuable insights into laboratory and 30-day prescription costs associated with each patient visit. Primary care clinic equipment and supplies were estimated from Medi-Cal Facility Site Standards published by the California Department of Health Care Services.

Based on these sources and current medication purchasing agreements available to the County, staff calculated an average per patient per visit (pppv) medication cost of \$90.61 for Section 340-B pricing and \$369.17 for non-340-B pricing to estimate program costs. Actual costs will vary depending on patient conditions and needs, method of delivery (on-site, mail or courier) and due to normal fluctuations in medication pricing and availability. Actual costs may also vary based on partnerships leveraged and options selected for implementation. Detailed information on the client case profiles and medication costs can be found in Appendix A.

Leveraging Section 340-B pricing could reduce medication costs by at least 70% for the same sample patients depending on negotiated pricing available through community partners and method of delivery. The options described in this analysis reflect pricing with and without leveraging 340-B pricing for medications. Options for incorporating food distribution into the Transitional Access Clinic model are described separately later in this report.

The next few tables represent staffing, infrastructure, and supply costs to operate a four-hour Transitional Access Clinic, serving an average of 17 patients. These costs would need to be scaled to meet the desired service capacity.

1. Telehealth Transitional Access Clinic

This option would create a low barrier method to access care and services associated with the Transitional Access Clinic model in a cost-efficient manner. The telehealth option is also well aligned to the volunteer provider model proposed as it also removes barriers for physicians to volunteer. The vision for this option is to potentially mobilize County volunteers for telehealth providers, provide medications to patients by mail, and arrange food delivery if needed. Patients seeking telehealth would also have access to an expedited reenrollment queue through Self Sufficiency Services. There are two distinct approaches the County could select to implement a Telehealth Transitional Access Clinic:

- a) Implement a County-operated program where County staff provide oversight and infrastructure and the clinic utilizes volunteer providers for care, or
- b) Contract with Community Health Center(s) with telehealth capacity, clinical staff, and access to Section 340-B pricing for medications to expand care.

Cost Estimate for Telehealth Transitional Access Clinic

Service Area	Approach	Estimated Cost Range
a) Provide care via telehealth with County volunteer providers -OR-		
Primary Care Services	County would coordinate and operate a telehealth Transitional Access Clinic with volunteer providers.	One-time: \$250,000 for telehealth platform. Staff time and other IT costs for implementation would be in addition to that estimate. Ongoing: Staffing \$922 - \$1,382 IT Costs \$12,000
Medication	Purchase and mail medications to patients via next day delivery without access to drug pricing discounts and Pharmacy Staffing	Staffing: \$1,067 – \$1,601 Non 340-B Pricing: Medications: \$6,276 for 30-day supply for 17 patients Mailing costs: \$170-\$765
Eligibility Services	Facilitate warm handoff to Self-Sufficiency Services for re-enrollment	Resource already in place
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$20,881 – \$22,693
b) Provide care via telehealth with Community Health Center(s)		
Primary Care Services	Leverages Community Health Centers which already have telehealth platforms, clinical staff, and access to Section 340-B pricing for medications.	Exact costs to be determined pending negotiations with existing providers to expand capacity. For this analysis, ongoing costs estimated at \$3,536 to \$3,740 per per 4-hour clinic

Medication	Purchase and mail medications to patients via next day delivery leveraging Section 340-B drug pricing discounts	340-B Pricing: Medication: \$1,540 ongoing for 30-day supply for 17 patients Mailing costs: \$170-\$765
Eligibility Services	County would provide a dedicated "Access Community Based Organization (CBO)" telephone line for CBOs to connect with County Self Sufficiency Services (SSS) staff for individuals who need benefit assistance	Resource already in place
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$5,692 - \$6,714

For the County-operated telehealth option staffed by County volunteers and supervised by County staff, the ongoing costs could range from \$20,881 to \$22,693 per each four-hour Transitional Access Clinic, which is anticipated to serve 17 patients. If the model is extended to provide six virtual clinic shifts weekly, the annual ongoing cost range is estimated at \$6.5 million to \$7.1 million, in order to provide an estimated 5,304 primary care patient visits per year. Ongoing costs for coordination of program and medical and operational oversight would be similar to other options proposed. Since this option would not require significant investment in physical space up front, it could be implemented in a relatively short timeline beginning with a pilot (possibly within one year).

In addition to the infrastructure needed for County-operated options described in the Methodology section, the proposed timeline accounts for purchase, planning and implementation of a telehealth platform that is compliant with County Technology and security standards. Market research indicates that there are a wide range of options available, both with and without an electronic health record. Depending on selections, costs could be up to \$250,000 plus County Information Technology vendor costs and staff time for implementation. Further research is needed to determine if the virtual telehealth platform is available to the County through the electronic health record system staff are currently implementing.

If telehealth services are provided by a Community Health Center, the ongoing costs could range from \$5,692 to \$6,714 and the timeline to implement could be much quicker

(3-6 months) as many community health centers have telehealth options currently available.

2. Expand Capacity at Existing Free Clinics

Currently, there are two entities operating free clinics in San Diego County, each with a distinct model. One entity operates with Volunteer in Medicine at a modular clinic in the east region of San Diego. The other is associated with the University of California, San Diego (UCSD) School of Medicine and operates four sites located in churches and schools in the central and east regions of San Diego. The five free clinic sites provide primary care, medication and behavioral health services, as well as limited specialty services, including dental.

Cost Estimate to Expand Capacity at Existing Free Clinics

Service Area	Approach	Estimated Cost Range
Primary Care Services	Add capacity to existing community-based free clinic(s) by identifying County facilities as clinic sites.	Exact costs to be determined pending negotiations with existing free clinic providers to expand capacity. For this analysis, ongoing costs estimated at \$6,490 to \$7,932 per 4-hour clinic Security costs for afterhours \$273
Medication	a) Contract with community-based free clinic provider to offset medication costs. This service model would not allow for discounted drug pricing through Section 340-B but may leverage discounts through patient assistance programs.	Non 340-B Pricing: Medication: \$6,276 for 30-day supply for 17 patients
	b) Purchase and mail medications to patients via next day delivery	Non 340-B Pricing: Medication: \$6,276 for 30-day supply for 17 patients Mailing costs: \$170-\$765

Eligibility Services	On-site eligibility staff to start the re-enrollment process	Ongoing: \$510 - \$765
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$14,165 - \$16,680

The total ongoing cost for this option could range from \$14,165 to \$16,680 per each four-hour clinic, which is anticipated to serve 17 patients. If the model is extended to provide these supplemental services at five existing clinics weekly, the annual ongoing cost range is estimated at \$3.7 million to \$4.3 million, in order to provide an estimated 4,420 patients with medication and eligibility assistance. The estimate would depend upon leveraging 340-B drug pricing and does not include specific costs to expand capacity of primary care and does not include negotiating with existing community-based free clinics. Initial discussions indicated assistance with medication costs, enrollment and re-enrollment in benefits and access to food may be the greatest areas of opportunity.

3. Mobile Medical Units at Live Well Centers

As an alternative to the physical infrastructure investments needed to prepare the Live Well Centers to operate a Safety Net Bridge program, the County could bring mobile medical units to the Live Well Center facilities to expand the services offered onsite.

Cost Estimate for Mobile Medical Units at Live Well Centers

Service Area	Approach	Estimated Cost Range
a) Partner with a Community Health Center to Operate a Mobile Clinic at Live Well Center(s) -OR-		
Primary Care Services	Partner with a Community Health Center with a Mobile Medical Unit to provide services outside a Live Well Center	Costs would depend on agreement with Community Health Center Ongoing: <ul style="list-style-type: none"> Security costs for afterhours \$273
Medication	a) Partner with a Community Health Center that can leverage Section 340-B pricing – OR -	Ongoing: <ul style="list-style-type: none"> 340-B Medications: \$1,540 for 30-day supply for 17 patients
	b) Utilize a Live Well on Wheels vehicle as a Mobile Pharmacy with limited formulary -OR-	Ongoing: <ul style="list-style-type: none"> Non 340-B Medications: \$6,276 for 30-day supply for 17 patients

	c) Utilize County Pharmacy to Mail medications to patients via next-day delivery or courier service	Ongoing: <ul style="list-style-type: none"> • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients • Shipping \$170-\$765
Eligibility Services	Currently on-site at Live Well Centers	No additional cost for onsite Human Services Specialists. Ongoing: <ul style="list-style-type: none"> • Bus Driver for mobile unit \$218 - \$326
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$2,647 - \$8,309
b) Operate a County-operated mobile clinic at Live Well Center(s)		
Primary Care Services	Use County Live Well on Wheels mobile medical unit to provide primary care services at Live Well Center(s)	Ongoing: \$6,078 - \$8,548 includes anticipated staffing, services and supplies, and laboratory tests
Medication	a) Utilize a Live Well on Wheels vehicle as a Mobile Pharmacy with limited formulary -OR-	Ongoing: <ul style="list-style-type: none"> • Staffing: \$1,067-\$1,601 • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients
	b) Utilize County Pharmacy to Mail medications to patients via next-day delivery or courier service	Ongoing: <ul style="list-style-type: none"> • Staffing: \$1,067-\$1,601 • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients Shipping \$170-\$765

Eligibility Services	Currently on-site at Live Well Centers	No additional cost for onsite Human Services Specialists. Ongoing: Bus Driver for mobile unit \$218 - \$326
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$14,255 - \$18,185

This option can be accomplished by partnering with local community health centers with mobile medical units or exploring the use of the County Live Well on Wheels as a primary care clinic. The current fleet of four Live Well on Wheels vehicles include one resource outfitted as a clinical space with one exam room. If one clinic shift operated by County staff is added at each of the six Live Well Centers, the annual cost range is estimated at \$4.4 million to \$5.7 million, without leveraging discounted drug pricing, and would serve an estimated 5,304 patients per year. Although the ongoing staffing costs to operate the clinics appear similar to the County-Operated Transitional Access Clinic option, this option could be implemented in a shorter timeline (within one year) as there is significantly less facility infrastructure investment needed.

If the County is able to establish mobile Transition Access Clinics in partnership with a community health center to leverage Section 340-B pricing, the clinics could serve the same number of patients for an estimated cost range of \$0.8 million to \$2.6 million annually, plus any payment negotiated to the community health center for the provision of primary care services.

For pharmacy services, the County could explore a mobile pharmacy unit with a limited formulary, or list of medications covered by the Safety Net Bridge program, contingent on implementation of appropriate security measures. Alternatively, pharmacy services for the Transitional Access Clinic could be provided using the same method as the Public Health Centers by mailing or using courier services to provide medications to patients. Although this method would not allow for same-day access to prescription medications, it could provide a more cost-effective option utilizing the existing centralized pharmacy team.

4. County-Operated Transitional Access Clinic at Live Well Centers

This option focuses on the opportunity to leverage any existing space within the County Live Well Centers to operate a primary care clinic, pharmacy and food distribution site with County staff.

Cost Estimate for County-Operated Clinics at Live Well Centers

Service Area	Approach	Estimated Cost Range
Primary Care Services	Establish a primary care clinic within a Public Health Center at a Live Well Center, and provide services with a combination of County staff and volunteers where appropriate/available	Involves significant upfront facility infrastructure investments. Cost estimate is still under development. Initial estimates of one-time costs identified that a minimum of \$11,514 in clinical equipment would be needed for each primary care clinic site, based on client case profiles and DHCS standards . Ongoing: \$6,078 - \$8,548 includes anticipated staffing, services and supplies, and laboratory tests
Medication	Build out and license a retail pharmacy at a Live Well Center, and provide medications on-site with County staff	Ongoing: <ul style="list-style-type: none"> Staffing: \$1,067-\$1,601 Non 340-B Medications: \$6,276 for 30-day supply for 17 patients
Eligibility Services	Currently on-site	No additional cost
Case Management	Provide community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$13,867 - \$17,094

The ongoing costs could range from \$13,867 to \$17,094 per each four-hour Transitional Access Clinic, which is anticipated to serve 17 patients. If the model is extended to provide one clinic shift at each of the six Live Well Centers weekly, the annual ongoing cost range is estimated at \$4.3 million to \$5.3 million, in order to provide an estimated 5,304 primary care patient visits. This projection does not include one-time costs to ramp

up the program. Implementation could take several years based on the amount of infrastructure readiness needed.

In addition to the infrastructure needed for all County-operated options described in the Methodology section of this report, this option may involve significant upfront investments in existing facilities as follows:

- Modifications to the current facilities to accommodate clinical needs and meet licensure requirements. Primary care clinics are licensed under Section 1200 of the California Health & Safety Code and must obtain licensure through the California Department of Public Health (CDPH) Licensing & Certification Program (L&C). Current Public Health Centers offer a limited range of clinical services focused on prevention of infectious disease. Using the assumption that the Transitional Access Clinics would operate outside of normal Public Health Center operational hours, exam rooms and staff spaces could be multipurpose. However, further assessment would be needed to determine specific space, equipment and supply needs currently absent.
- Modifications to the current facilities to accommodate Pharmacy needs and meet licensing requirements (backup generator, HVAC specifications, etc.). The County does not currently have a licensed retail pharmacy at any PHC. The HHS Pharmacy supports Behavioral Health outpatient clinics and PHCs (mainly for sexual health and tuberculosis services) through a centralized pharmacy and delivers prescriptions via mail or couriers.
- Costs associated with relocating existing programs to accommodate Transitional Access Clinics in Live Well Centers as several sites are at capacity.

5. Community Health Fairs

While options three and four focus on serving individuals who come to Live Well Centers, the Community Health Fair option emphasizes meeting people where they are to provide services in neighborhoods and places where people gather.

Cost Estimate for Community Health Fairs

Service Area	Approach	Estimated Cost Range
a) Partner with a Community Health Center to Operate a Mobile Clinic at community sites -OR-		
Primary Care Services	Add capacity to existing community-based free clinic(s)	Estimated cost provided by a local CBO is \$10,000 per community health fair event based on their expenses for 10 primary care visits,

		additional rapid lab tests, and food
Medication	a) Partner with a Community Health Center that can leverage Section 340-B pricing – OR -	Ongoing: <ul style="list-style-type: none"> • 340-B Medications: \$1,540 for 30-day supply for 17 patients
	b) Utilize a Live Well on Wheels vehicle as a Mobile Pharmacy with limited formulary -OR-	Ongoing: <ul style="list-style-type: none"> • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients
	c) Utilize County Pharmacy to Mail medications to patients via next-day delivery or courier service	Ongoing: <ul style="list-style-type: none"> • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients • Shipping \$170-\$765
Eligibility Services	Utilize a Live Well on Wheels vehicle for on-site eligibility staff to start the re-enrollment process	Ongoing: \$727-\$1,091 (includes bus driver)
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$12,883 - \$18,801
b) Operate a County-operated mobile clinic at community sites		
Primary Care Services	Use County Live Well on Wheels mobile medical unit to provide primary care services at community sites	Ongoing: \$6,078 - \$8,548 includes anticipated staffing, services and supplies, and laboratory tests
Medication	a) Utilize a Live Well on Wheels vehicle as a Mobile Pharmacy with limited formulary -OR-	Ongoing: <ul style="list-style-type: none"> • Non 340-B Medications: \$6,276 for 30-day supply for 17 patients
	b) Mail medications to patients via next-day delivery or courier service	Ongoing \$170-\$765

Eligibility Services	Utilize a Live Well on Wheels vehicle for on-site eligibility staff to start the re-enrollment process	Ongoing: \$727- \$1,091 (includes bus driver)
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Ongoing: \$446 - \$669
TOTAL ONGOING COST RANGE PER 4-HOUR CLINIC SERVING AN AVERAGE OF 17 PATIENTS		\$13,698 - \$17,350

Similar to the Mobile Medical Unit option, the Community Health Fair option can be accomplished by partnering with local community health centers for use of mobile medical units or exploring use of the County Live Well on Wheels to conduct Transitional Access Clinics. This option could be utilized to expand the capacity and reach of existing, proven Community Health Fair models. Community partners, including the HHS regional community leadership teams, could support identifying sites. A priority would be to ensure continuity of care for residents so patients can continue to receive care with their primary care provider and avoid duplication of services.

This option would have minimal upfront infrastructure costs compared to readying a brick-and-mortar clinic space in a Live Well Center, with the most expedient option being to partner with an existing community health fair footprint, and/or a provider with an existing mobile clinic. Like the prior option presented, if the County coordinated and staffed six clinic shifts across the region each week and was not able to leverage discounted drug pricing, the annual cost range is estimated at \$4.3 million to \$5.4 million to serve an estimated 5,304 patients. Although the ongoing staffing costs for Community Health Fairs appear similar to the prior options, there is significantly less infrastructure investment needed and if pursued in partnership with an existing local healthcare provider, this option could be implemented within three to six months.

In addition to mailing medications to patients, the County could also explore including a mobile pharmacy unit with a limited formulary if the Community Health Fair sites allow and security measures are taken.

6. Contract with Community Health Centers for Medical Care and Linkage to Social Services

In alignment with Board Policy A-67 on Primary Care Services, the County's indigent health care as required by State law, is called County Medical Services (CMS). The CMS program is fully funded by County revenue to assist medically indigent adults who are not eligible for other government health care programs. The County does not provide direct services for CMS. Services are provided by primary care clinics, local hospitals, and physicians that contract with the County to provide medical care reimbursable at Medi-

Cal rates. The County also contracts with an Administrative Services Organization (ASO) to operate, manage, and administer provider payments for the CMS program. CMS is not health insurance; rather, it covers a limited scope of necessary medical services for eligible individuals and may include primary care physician services, outpatient and inpatient services, emergency medical and dental services, and some prescription medication, vision care, specialty care physician services and rehabilitation services. As of January 2026, one person is enrolled in CMS in San Diego County.

Under its current rules, CMS would not meet this need. However, using a similar approach to CMS, the County could explore contracting with existing care providers to subsidize costs. This option would allow people to keep their same providers and ensure costs are kept minimal for patients with minimal upfront costs.

Cost Estimate to Contract with Community Health Centers for Medical Care and Linkage to Social Services

Service Area	Approach	Estimated Cost Range
Primary Care Services	Contract(s) with existing primary care providers to cover the cost of medical visits, medication, and food	Ongoing: \$3,536 to \$3,740 per 17 patient cohort
Medication	Provider reimbursed for costs	Incorporated in per visit cost
Eligibility Services	Dedicated CBO telephone line for CBOs to connect with SSS	Resource already in place
Case Management	Provide County or contracted community health workers or patient navigators to assist with linkage to additional resources and follow up.	Community Health Centers have these resources in place.
TOTAL ONGOING COST RANGE PER 17 PATIENTS		\$3,536 to \$3,740

The County currently has reimbursement agreements with approximately 50 primary care clinic sites for CMS clients. This option involves leveraging existing CMS agreements and paying an estimated rate of \$200 per visit to reimburse providers for visits that would include primary care services, medication, and food. The proposed per visit rate aligns with Medicare rates plus prescriptions and access to food. Using the single shift model, reimbursement for 17 patients would be \$3,400 plus the administrative services organization fee for processing, which could add 4-10%, making the estimated cost from \$3,536 to \$3,740. To compare to this the other options presented, if the County subsidized for the same 5,304 patients in previous options, the anticipated cost would be approximately \$1.1 million. This estimate does not include County program administration costs and any additional ASO fees to adjudicate claims. This option could be implemented within one year pending contract negotiation timelines.

Food Access Options

In addition to enrolling eligible residents in CalFresh, the County has ongoing partnerships with regional food banks and other partners to distribute food at County Live Well Centers, parks, and libraries. For example, on a weekend in November, the San Diego Food Bank hosted a pop-up event at the Chula Vista Family Resource Center and provided food to more than 200 households. The County also partners to support meal programs across various County departments and locations and over 40 certified farmers markets in the region, nearly half of which accept CalFresh.

As part of the Food Justice Community Action Plan (FJCAP), the Office of Sustainability and Environmental Justice (OSEJ) and departments across the County enterprise are working on eleven Board-directed actions that the County can take in the near-term to improve food access and reduce food insecurity in the region. All eleven actions grew from community-identified priorities and recommendations. Based on the themes selected by the Board, departments are currently working on the following:

- Expanding opportunities for community food production, including community gardens
- Supporting edible food recovery systems, infrastructure, and food hubs
- Enhancing County and community collaboration and engagement
- Promoting transparency and increasing safety nets, and supporting legislation related to food security
- Updating emergency response plans to include community input on food access

Departments are on track with their FJCAP actions, some of which require future Board direction for implementation. Draft strategies for these items will be shared with the Board in Spring 2026 and final strategies in Summer 2026; there may be future fiscal impacts and resources needed. Strategies and actions included in the FJCAP would directly inform and support implementation of the food access component of the Safety Net Bridge initiative. Food access options available to support transitional access clinics would vary based on clinic option selected and could include:

Cost Estimate for Food Access Options

Service Area	Approach	Estimated Cost Range
Food	✓ Add purchased or leased cold storage capacity at a County owned facility, either within the facility or with a refrigerated container immediately outside the facility	Costs for cold storage capacity options are anticipated to be included in the Spring/Summer 2026 memo.
	✓ Purchase or lease a refrigerated truck for County mobile use	One-Time: \$10,000 for initial costs

		Ongoing: \$400-\$1,500 monthly to lease the truck, plus delivery and utility costs as well as the cost for a driver
✓	Support local food bank/pantry/hub with purchase of a new refrigerated truck	Costs are still being determined for one-time vehicle purchase, as well as ongoing storage, insurance, fuel, and maintenance
✓	Support local food distribution organizations to increase cold food storage capacity	Costs for cold storage capacity options are anticipated to be included in the Spring/Summer 2026 memo
✓	Support local food distribution organizations to expand the number of households served through increased number of events/sites	Costs are still being determined for event staffing needs and logistics
✓	Support local food distribution organizations through increased storage of non-perishable food options	Costs are still being determined for shelf-stable storage and distribution requirements

As part of continued engagement under the FJCAP, OSEJ has been connecting with community partners related to edible food recovery, cold storage capacity, and food access to inform draft strategies. Preliminary findings confirm that there is a need for expanded and decentralized cold storage and refrigerated transportation vehicles to support food recovery and distribution organizations. Shared and localized cold storage units and vehicles improve efficiency of operations, reduce transportation time and miles driven, support compliance with Senate Bill 1383 on preventing wasted food, and allow for more fresh food to be collected and distributed to those in need. These priorities will be central to draft FJCAP strategies being developed, as well as opportunities to expand partnerships to strengthen local food security.

One learning model is the installation of four free-standing and self-sustaining solar-powered freezers in Orange County to support storage of excess restaurant food converted into meals for emergency food relief for the area through a partnership between Radiant Innovation and Abound Food Care. According to Abound Food Care, these units have no plug-in requirements and have been operating in Orange County for two years. The OSEJ team has connected with Abound Food Care to learn more and understand if a similar approach may apply in San Diego County, including the costs associated with this effort.

Food access and distribution efforts go beyond identifying a physical location for food hubs and cold storage. Implementation also requires planning for operational “soft costs,” such as staffing, coordination, outreach, storage, and logistics to ensure food can be distributed equitably.

To help address these operational needs, as part of the Food Hub action item under FJCAP, one approach being explored is the use of the County’s Temporary Employee Professional (TEP) program to build capacity. TEPs have previously supported regional food system efforts, including food hub development and technical assistance for farmers markets. While these positions were historically funded through now-expired state and federal grants, the model represents a potential pathway to bolster food access and distribution infrastructure through early-stage program design and development if alternative funding sources are identified.

The County has financially supported food access on an annual basis through programs such as ¡Más Fresco! ¡Más Fresco! provides nutrition incentives that help low-income residents purchase fresh fruits and vegetables or receive home-delivered produce boxes. Through partnerships with local farms, retailers, and community organizations, the program helps connect residents with healthy food options while also supporting the region’s agricultural economy. The continuance of this program is dependent on continued funding allocations. Another approach to food distribution involves leveraging County-owned facilities as community-based food hubs. Existing programs show this is already happening in practice. Through partnerships with nonprofit organizations such as Heaven’s Windows, the Department of Parks and Recreation provides food distribution at teen centers in Spring Valley and Lakeside and operates a food pantry at Goodland Acres Park. Additionally, facilities like the Fallbrook Community Center provide space that support senior lunch programs, ensuring older adults have consistent access to nutritious meals.

Similarly, the San Diego County Library partners with regional food banks and community organizations to host summer meals, year-round and seasonal pantries, senior meals, and afterschool snack programs. In total, 26 food access programs currently operate across 16 library branches expanding food access for children, seniors, and families in need.

These examples demonstrate how County facilities can serve as trusted community hubs that support food access and distribution. At the same time, implementing and sustaining these programs requires coordination across County departments and community partners, as well as staff capacity to support program planning, outreach, and logistics, as well as balance the needs of core programs and day-to-day operations. Consideration of these operational realities is important when exploring opportunities to expand food distribution efforts through existing County facilities.

Next Steps

The Safety Net Bridge Feasibility Analysis Report describes six options to implement Transitional Access Clinics, which support the Safety Net Bridge program and provide primary care, prescription medications, and nutritious food to people experiencing a temporary gap in Medi-Cal and other public benefits due to administrative changes in Medicaid due to H.R. 1. On March 3, 2026 (17), the Board of Supervisors directed the Chief Administrative Officer to analyze and make recommendations for reforms to County Medical Services and Board Policy A-67 on Primary Care Services, the County's indigent health care as required by State law. The Safety Net Bridge program framework will need to coordinate and align with any changes to the County's indigent care program.

Proposed Pilot Design

County staff recommend a **phased approach to pilot design and implementation, focusing efforts for a six-month period in one to four ZIP codes identified as geographically high-need areas where Medi-Cal disenrollment is most likely using the criteria described in the Methodology section. Partnering with a Community Health Center in each area as the type of provider is recommended in order to expedite pilot implementation, as contracts, infrastructure, and capacity are already present.**

Examples of six-month Pilot Cost per Zip Code and Options selected

Type of Transition Access Clinic	Cost Range
Telehealth Clinics (1 clinic weekly x 26 weeks)	\$147,992 to \$590,018
Mobile Medical Unit at Live Well Center	\$334,958 to \$472,810
Contract with Community Health Center(s) for clinics	\$91,936 to \$137,280
Community Health Fair with Mobile Medical Unit (1 event monthly x 6 months)	\$77,298 to \$112,806

Pilot findings would inform expansion and refinement of Transition Access Clinic models. Longer-term decisions, including potential pursuit of FQHC look-alike status, infrastructure investments, and partnership structures, will depend on available funding, policy guidance, and identified community needs.

Implementation Plan

The following is a high-level, data-driven action plan to develop and implement the pilot and subsequent Transitional Access Clinic options.

<p>1. Identify Location for the pilot and subsequent Transitional Access Clinics</p>	<ul style="list-style-type: none"> ✓ Map Medi-Cal population density; develop an interactive map and dashboard that reflect Medi-Cal population density by age and aid code, to identify where people live who are most likely to experience a gap in Medi-Cal benefits. <ul style="list-style-type: none"> ○ Identify the ZIP codes with the highest density of Medi-Cal recipients likely to experience a gap in Medi-Cal benefits. ○ Identify the ZIP codes with the highest proportion of Medi-Cal recipients likely to experience a gap in Medi-Cal benefits. ✓ Social Vulnerability Index: Overlay the ZIP codes identified above with the Social Vulnerability Index, to further highlight the geographical areas in which the most vulnerable Medi-Cal recipients live. ✓ Determine the location for the pilot
<p>2. Identify Demographics and Population served by pilot and subsequent Transitional Access Clinic(s)</p>	<p>Identify characteristics of Medi-Cal recipients in service area of the Transitional Access Clinic, including but not limited to:</p> <ul style="list-style-type: none"> ✓ Total number of people at risk of losing coverage because of Work Requirements (Medi-Cal aid code M1, otherwise known as Able Bodied Adults Without Dependents- ABAWD) ✓ Estimate the percentage of this subpopulation who might experience a gap in enrollment (target population for pilot) ✓ Estimate the percentage of people who might access primary care during a gap in coverage, including but not limited to those with a chronic medical condition requiring medications ✓ Estimate the ages of people who are most likely to access primary care during a gap in coverage

<p>3. Select Transitional Access Clinic Options</p>	<ul style="list-style-type: none"> ✓ Identify Community Providers near Transitional Access Clinic locations <ul style="list-style-type: none"> ○ Free Clinic Sites ○ Live Well Centers ○ Community Health Fairs ○ Community Health Centers (including FQHCs, FQHC look-alikes, and Indian Health Clinics) ✓ Identify Potential Partners to develop each of the six Transitional Access Clinic options <ul style="list-style-type: none"> 1. Telehealth Transitional Access Clinic A low-barrier, scalable virtual model leveraging County volunteers or Community Health Centers. <ul style="list-style-type: none"> • Community Health Centers have established IT infrastructure and staffing for telehealth visits, helping patients establish a medical home and linking them with additional health and social care services. Community Health Centers are located throughout the region. • Develop a county-operated telehealth clinic by investing in telehealth platforms, clinical staffing, and pharmacy strategies. This would require developing a new County service. 2. Expand Capacity at Existing Free Clinics Two free clinic providers currently exist in the region. Expanding clinic sites and hours, medication support, and eligibility assistance will enable additional people to receive care. <ul style="list-style-type: none"> • One free clinic system is part of a medical school, and is staffed by students, volunteer physician preceptors, and employed clinic directors. There are four sites, currently in Central and East areas of the region. • Another free clinic is staffed by clinical volunteers. It is located in the East region. 3. Mobile Medical Units at Live Well Centers Deploys mobile clinics at County Live Well Centers. Timelines are shorter than brick-and-mortar clinics but require pharmacy solutions and staffing.
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- Community Health Centers have existing mobile medical units, which can be deployed to County Live Well Centers and provide primary care services and linkage to existing health and social care services, including food and medications.
- County has a mobile medical unit, which could be equipped and deployed to County Live Well Centers to house a primary care medical clinic. The County would need to invest in an electronic health record, clinical staffing, and pharmacy strategies.

4. County-Operated Transitional Access Clinics in Live Well Centers

Establishes permanent primary care clinics within existing County facilities. This option requires the most significant infrastructure, licensing, and information technology (IT) investments.

5. Community Health Fairs

Provides flexible, geographically targeted services through mobile medical units in partnership with community health centers. This option supports “meeting people where they are,” especially for persons without an established primary care provider. Mobile medical unit options include:

- Community health center (including medical, food and pharmacy services)
- County Live Well on Wheels mobile medical unit, staffed by County clinicians, volunteers, and pharmacy team to purchase, fill, dispense, and deliver meds

6. Contract with Community Health Centers for Medical Care and Linkage to Social Services

Subsidizes visits, medication, and food through existing clinic contracts (similar to the County Medical Services model), enabling residents to remain with their established primary care providers and clinic. Medications are provided at 340B discounted costs.

- Telehealth services provided by the community health center

	<ul style="list-style-type: none"> • In-person visit with FHQC Medical Home
<p>4. Develop Infrastructure, Finance, Planning and Operations</p>	<p>Infrastructure needed will depend on the option(s) selected and the needs of the community. Barriers to care will need to be addressed and minimized to ensure access to and utilization of the Transition Access Clinic(s).</p> <ul style="list-style-type: none"> ✓ Contracts including with Free Clinics, Community health centers, Community Health Fair leases or agreements, and any contracts or notification needed with State/Regulation ✓ Gather community and partner input to determine: <ul style="list-style-type: none"> ○ Languages, location, hours ○ Appointment processes ○ Services needed (ie, adult, pediatric, etc) ○ Location, transportation, option(s) to deliver care ○ Start Date ○ Communication/Advertisement ✓ Staffing models <ul style="list-style-type: none"> ○ Free Clinics and Community health centers provide their own staffing, inclusive of telehealth, mobile medical unit, and brick and mortar locations) ○ County staffed services (inclusive of Live Well Center, mobile medical unit, and telehealth) could require: <ul style="list-style-type: none"> ○ Security ○ Clinic Supervision (Provider, Nursing, OA) ○ IT support ○ Pharmacy support ○ QA and chart review ○ Contract, Compliance, Legal ○ Billing for MAA, etc ○ Data and Reporting ○ Audits ○ Administrative support (including credentialing and malpractice) ✓ Supplies

	<ul style="list-style-type: none"> ○ Community health center (virtual and in person clinics and mobile medical units)- no County purchasing of supplies needed ○ Medical equipment (Pulse oximeter, otoscope, ophthalmoscope, blood pressure cuffs, stethoscope, scales, EKG, nebulizer, peak flow) ○ Crash cart and emergency medications ○ IT equipment (laptops, electronic health record, dedicated phone lines, appointment systems, mobile devices. ○ Primary Care supplies (masks, wound care, point of care lab tests for flu, blood sugar, urine, COVID, etc)
5. Develop Communication Plan	<ul style="list-style-type: none"> ✓ Central phone line or phone tree and appointment/eligibility process ✓ If individual has established care at a community health center, then transfer call to that community health center’s appointment line. ✓ Dedicated Web page/QR code(s) for Pilot ✓ Group email address for Pilot
6. Go-Live	<ul style="list-style-type: none"> ✓ Manage pilot (finance, planning, operations, staffing, schedule, appointments/eligibility, service delivery, outcomes, communications, reporting)
7. Ongoing Monitoring of Pilot	<ul style="list-style-type: none"> ✓ All aspects above: administer care, supervise operations, monitor ✓ Maintain Supplies, Staff, Infrastructure ✓ Report utilization data and costs

Appendices

Appendix A: Client Case Profiles & Medication Costs

In order to generate an accurate representation of costs associated with prescription medication, clinical staff developed “client case profiles” as realistic examples of medications prescribed in a Transitional Access Clinic. The case profiles were based on published rates of Medicaid client health conditions and confirmed through conversations with local Medical Directors and physician leaders. Clinical pharmacists then identified cost-effective medications to treat each client’s conditions, based on standard treatment criteria. Medication cost estimates reflect County wholesale purchasing rates as of February 2026. This provided average 30-day prescription costs associated with each “client case” visit.

Of note, the medication costs below were those costs available as of February 2026. Both retail and 340B medication costs fluctuate over time, and these serve as estimates.

Sample Patient Profile & Conditions	Medications	Non-340B Cost	340B Cost
Patient 1: 46-year-old male smoker with diabetes, hypertension, high cholesterol, and emphysema	Metformin 1000mg BID	\$1.32	\$0.50
	Atorvastatin 40mg daily	\$1.80	\$0.28
	Lisinopril 20mg	\$1.35	\$0.28
	Nicotine Patches 21mg daily	\$55.76	\$19.00
	Symbicort 160/4.5mg BID	\$221.08	\$67.22
Total Cost per 30-day medication supply		\$281.31	\$87.28
Patient 2: 39-year-old female with hypertension, depression, low thyroid, anemia, and asthma	Lisinopril 40mg daily	\$1.35	\$0.28
	Amlodipine 5mg daily	\$0.50	\$0.25
	Levothyroxine 100mcg daily	\$1.15	\$0.28
	Sertraline 150mg daily	\$3.29	\$0.42
	Ferrous Sulfate 325mg daily	\$0.30	\$0.30
	Advair 2 puffs twice daily	\$150.00	\$25.95
Total Cost per 30-day medication supply		\$156.59	\$27.48
Patient 3: 13-year-old male with asthma, anxiety, and attention-deficit/hyperactivity disorder	Advair 2 puffs daily	\$150.00	\$25.95
	Sertraline 50mg daily	\$0.10	\$0.28
	Adderall 20mg daily	\$20.00	\$2.26

Sample Patient Profile & Conditions	Medications	Non-340B Cost	340B Cost
Total Cost per 30-day medication supply		\$170.10	\$28.49
Patient 4: 64-year-old female with diabetes, hypertension, congestive heart failure, high cholesterol, kidney failure, osteoporosis	Lantus 15 units daily	\$58.00	\$8.45
	Metformin 1000mg daily	\$1.32	\$0.35
	Rybelsus 14mg daily	\$962.67	\$296.22
	Jardiance 25mg daily	\$461.37	\$0.28
	Lisinopril 40mg daily	\$1.35	\$0.28
	finerenone 10mg daily	\$633.14	\$392.05
	Alendronate weekly	\$1.42	\$0.18
Total Cost per 30-day medication supply		\$2,119.27	\$697.81
Patient 5: 42-year-old female with hypertension, history of breast cancer treatment within the past 5 years, arthritis, depression	Amlodipine 10mg daily	\$0.50	\$0.19
	Anastrozole 1mg daily	\$3.80	\$0.28
	Acetaminophen 1000mg every 8 hrs as needed	\$0.30	\$1.67
	Sertraline 200mg daily	\$3.50	\$0.56
Total Cost per 30-day medication supply		\$8.10	\$2.70
Patient 6: 58-year-old male with obesity, hypertension, coronary heart disease with prior heart attack, high cholesterol, emphysema, congestive heart failure	Lisinopril 40mg daily	\$1.35	\$0.28
	Aspirin 81mg daily	\$0.50	\$0.32
	Atorvastatin 80mg daily	\$2.50	\$0.28
	Metoprolol Succ 200mg daily	\$51.93	\$0.28
	spironolactone 50mg daily	\$8.96	\$0.28
	Trelegy 1 puff daily	\$291.08	\$111.43
Total Cost per 30-day medication supply		\$356.32	\$112.87
Patient 7: 61-year-old male with diabetes, cellulitis, dementia, high cholesterol	Metformin 1000mg daily	\$1.32	\$0.50
	Atorvastatin 40m daily	\$1.80	\$0.28
	Donepezil 10mg daily	\$2.20	\$0.44
Total Cost per 30-day medication supply		\$5.32	\$1.22
	Metformin 1000mg BID	\$1.32	\$0.50

Sample Patient Profile & Conditions	Medications	Non-340B Cost	340B Cost
Patient 8: 46-year-old male with diabetes, hypertension, and high cholesterol	Atorvastatin 40mg daily	\$1.80	\$0.28
	Lisinopril 20mg	\$1.35	\$0.28
Total Cost per 30-day medication supply		\$4.47	\$1.06
Patient 9: 32-year-old female taking birth control	Northindrone 0.35mg daily	\$6.42	\$1.64
Total Cost per 30-day medication supply		\$6.42	\$1.64
Patient 10: 58-year-old with post-menopausal bleeding	Estradiol 1mg daily	\$1.69	\$0.64
	Ferrous sulfate 325mg every other day	\$0.15	\$0.15
Total Cost per 30-day medication supply		\$1.84	\$0.79
Patient 11: 50-year-old female with diabetes, hypertension, high cholesterol, emphysema, asthma, coronary heart disease	Metformin 1000mg twice daily	\$1.32	\$0.50
	Jardiance 25mg daily	\$461.37	\$0.28
	Amlodipine 10mg daily	\$0.50	\$0.27
	Atorvastatin 40mg daily	\$1.80	\$0.28
	aspirin 81mg daily	\$0.50	\$0.32
	Trelegy 1 puff daily	\$291.08	\$111.43
Total Cost per 30-day medication supply		\$756.57	\$113.08
Patient 12: 61-year-old female with atrial fibrillation, hypertension, history of a stroke	Eliquis 5mg twice daily	\$559.00	\$11.89
	aspirin 81mg daily	\$0.50	\$0.32
	atorvastatin 80mg daily	\$2.54	\$0.28
	Lisinopril 40mg daily	\$1.35	\$0.28
	HCTZ 25mg daily	\$0.38	\$0.13
Total Cost per 30-day medication supply		\$563.77	\$12.90
Total cost of medications for 12 patients in client case profiles		\$4,430.08	\$1,087.32
Average medication cost per patient per month to apply to Transition Access Clinic Model		\$369.17	\$90.61