EXHIBIT A

Matthew J. Silveira, Bar No. 264250
msilveira@jonesday.com
JONES DAY
555 California Street, 26th Floor
San Francisco, California 94104
Telephone: +1.415.626.3939
Facsimile: +1.415.875.5700

Attorneys for Amicus Curiae
California Hospital Association

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

CALIFORNIA PRIMARY CARE ASSOCIATION; OPEN DOOR COMMUNITY HEALTH CENTERS,

Plaintiffs,

v.

SHIRLEY N. WEBER, PH.D., in her official capacity as Secretary of State of the State of California; SERVICE EMPLOYEES INTERNATIONAL UNION – UNITED HEALTHCARE WORKERS WEST, as a real-party-in-interest proponent of California Ballot Initiative 25-0008; SHAWNA BROWN, in her capacity as the official proponent of California Ballot Initiative No. 25-0008; and SEAN FLEMING, in his capacity as the official proponent of California Ballot Initiative No. 25-0008,

Defendants.

Case No. 3:26-cv-03837-AGT

BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Judge: Hon. Alex G. Tse

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Other Authorities

ARGUMENT[1]

Plaintiffs seek to enjoin publication of Initiative No. 25-0008 (the "Initiative")—CHA writes to explain why the public interest demands no less. *See Diamond Sands Apartments, LLC v. Clark County*, 164 F.4th 759, 761–62 (9th Cir. 2026) ("public interest" influences propriety of injunction).

Community health centers ("CHCs"), also referred to as federally qualified health centers, are an integral part of California's safety net. These patient-governed nonprofit organizations provide primary, mental health, substance abuse, behavioral, dental, and preventive services to underserved patients regardless of insurance status or ability to pay. *E.g.*, Starr Decl. ¶¶ 14–16; Sanchez Decl. ¶¶ 14–19. Additionally, CHC practitioners see patients who need hospital-level care and provide critical follow-up care immediately following an inpatient discharge. By facilitating access to care and coordinating and collaborating with hospitals and other providers, CHCs serve a unique and vital role that supports patient access, quality of care, and safety in a rapidly evolving and already strained health care environment under considerable strain.

The Initiative directly threatens to seriously impair, if not close, CHCs that serve as the primary, or only, source of care for millions of low-income, uninsured, and underinsured Californians. Plaintiffs and their supporters ably make that point. *See* Pls.' Mot. Prelim. Inj. 24–28; Hamm Decl. ¶ 14; Sanchez Decl. ¶ 49. But the Initiative's impact goes even further.

When CHCs close or reduce services, patients lose access to a critical source of care. By necessity, former CHC patients turn to hospitals. Without access to CHC services, some patients will seek replacement care in emergency departments. Others will defer care until preventable conditions become acute. That delay risks worse outcomes and creates more demand for hospital-level care. But regulatory and practical realities make it impossible for hospitals to expand licensed capacity on the timeline the Initiative demands.

[1] No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution to fund the preparation or submission of this brief. No person or entity other than amicus, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

If passed, the Initiative will impair the most vulnerable Californians' ability to obtain care. Hoping it fails is not enough. The Initiative's ripple effects are already expanding and will only intensify as the election nears. The public interest thus weighs heavily in favor of injunctive relief. *See Diamond Sands*, 164 F.4th at 761–62.

I. CHC closures will send patients to already-crowded emergency departments.

CHC closures risk overwhelming already overcrowded hospital emergency departments. CHCs serve the most vulnerable Californians: nearly 2,300 CHC sites annually serve 6.2 million patients who are disproportionately minority and low-income. Silva Decl. ¶¶ 3–5. Many are homeless or migrant workers. *Id.*; *see also* Sanchez Decl. ¶¶ 7–9 (composition of CHC patients). CHCs convert government funding and private donations into primary and specialized care for these patients. *E.g.*, Starr Decl. ¶¶ 14–16; Sanchez Decl. ¶¶ 14–19. In short, CHCs "provide a vulnerable segment of the population with preventive and essential medical care, with the hope of reducing more extreme and expensive medical interventions." Berkeley Rsch. Grp., *Study of Potential Impacts from the Clinic Funding Accountability and Transparency Act* 4 (2025). Indeed, "the original role and mandate of CHCs was to serve uninsured persons and decrease the burden on hospital emergency rooms." Daniel A. Nagel, Lisa Keeping-Burke & Isdore Chola Shamputa, *Concept Analysis and Proposed Definition of* Community Health Center, 12 J. Primary Care & Cmty. Health, at 2 (2021), https://doi.org/10.1177/21501327211046436. When CHCs close or trim services, their patients still need screenings, counseling, medication management, dental care, behavioral health services, and chronic-care support.

If CHC services disappear, many patients will turn to the only other place that cannot turn them away: the emergency department. *See* George Rust et al., *Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties*, J. Rural Health, Winter 2009, at 8, 9, https://doi.org/10.1111/j.1748-0361.2009.00193.x (studies show that "[a]ccess to affordable health care through a CHC may reduce unnecessary reliance on EDs among the uninsured"). For patients experiencing a health crisis, the reasons for going to the emergency department are obvious. Patients do not choose emergency department care—they are driven there, sometimes by an actual emergency, sometimes by a lack of alternatives. *See* Gabor D. Kelen et al.,

Emergency Department Crowding: The Canary in the Health Care System, NEJM Catalyst, at 7 (2021), https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217 ("Patients seek ED care because alternatives are difficult due to factors such as general lack of outpatient services, inadequate primary care capacity, unavailability of after-hours care, and lengthy waits for primary and specialty care appointments.").

For displaced CHC patients, the choice is not whether to turn to the emergency department, but when. For individuals with chronic care issues or without options for preventive care to foreclose more acute issues, some will go regularly to emergency departments for services that CHCs previously provided. *See* Cal. Hosp. Ass'n, *Emergency Departments' Overcrowding Crisis* 2 (2025), https://calhospital.org/file/apot-2025-infographic/ ("Lack of community resources cause more patients in need of care to visit the ED."); Claire Morley et al., *Emergency Department Crowding: A Systematic Review of Causes, Consequences and Solutions*, PLoS One 13(8): e0203316, at 26 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6117060/ ("Poor access to primary care was identified as a cause of ED crowding . . . ."); Sanchez Decl. ¶ 10 (describing the primary care, behavioral health, substance abuse and other services CHCs provide). Others will wait, forgoing routine care, until an actual emergency that may have otherwise been prevented through CHC encounters and interventions. *See* Kelen et al., *supra*, at 7 ("impediments" to primary care "lead to poor control of chronic illness, which, in turn, lead to increased likelihood of decompensated illness presenting to EDs").

For California's most vulnerable patients, CHCs are often the first available safety net. But emergency departments are "the 'safety net of the safety net,' catching patients who fall through the cracks of primary care and social services systems." Julia B. Nath et al., *Access to Federally Qualified Health Centers and Emergency Department Use Among Uninsured and Medicaid-insured Adults: California, 2005–2013*, PubMed. Cent., at 2 (2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6370496/pdf/nihms973829.pdf; *see also* Rust et al., *supra*, at 12–13 (presence of CHC in rural counties significantly reduced uninsured ED visits). If the Initiative forces CHCs to reduce access or close, their patients will fall through the first safety

net, landing in already crowded emergency departments and likely requiring additional care and interventions for medical and health issues aggravated by the lack of CHC access.

Emergency departments do not have room to spare. Overcrowding "is already the persistent norm," so the CHC closures threatened by the Initiative make an existing problem worse. Kelen et al., *supra*, at 2. Before the COVID pandemic, more than "90% of U.S. EDs found themselves stressed beyond the breaking point at least some of the time." *Id.* CHC closures will add patients on top of the normal emergency caseload and non-emergency patients referred to the emergency department by "[primary care providers] and specialists" for "imaging, laboratory ancillaries, and consults." *Id.* at 9 Tbl.1.

Whether they are seeking primary care or facing emergent issues related to untreated conditions, displaced CHC patients will exacerbate emergency department overcrowding.

II. CHC closures or service cutbacks means CHA's member hospitals will see more high-acuity patients who need inpatient services and who arrive at the hospital too late for even the best care to achieve the best outcomes.

CHCs protect population health, so closures will mean sicker patients and more inpatient demand. CHC care addresses medical, mental health, and substance-abuse issues before they manifest as acute crises or late-stage disease. They "facilitate[e] chronic disease management, address[] health risks[,] . . . and provid[e] screening." Nagel et al., *supra*, at 6–7. When clinics disappear, disease does not. Without reliable preventive care, CHC patients see their health deteriorate, presenting to hospitals as high-acuity patients in need of treatment they should have had weeks, months, or years earlier, and hoping for outcomes that are no longer realistic.

Consider a few ways that CHCs take the pressure off emergency departments. They provide behavioral health services, Silva Decl. ¶ 4, but when behavioral health disorders go untreated, emergency departments are left with "acutely decompensated psychiatric patients," Kelen et al., *supra*, at 7. CHCs are also a critical resource to manage diabetes and hypertension—in 2024 alone, U.S. health centers helped 3.6 million and 2.2 million patients control their hypertension and diabetes, respectively. *Impact of the Health Center Program*, Health Res. & Servs. Admin. (Aug. 2025), https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program. In California, those two chronic conditions burden emergency departments more than any others.

Emergency Department Volume and Capacity by Facility, Health Category and Health Professional Shortage Area, HCAI, https://hcai.ca.gov/visualizations/emergency-department-volume-and-capacity-by-facility-health-category-and-health-professional-shortage-area/ (last visited June 16, 2026) (from 2021–2023, hypertension and diabetes had more ED visits by station than any other health topics).

Take away CHCs, and their patients' chronic conditions convert into high-acuity trips to the emergency department and inpatient stays. *See* Janice C. Probst, James N. Laditka & Sarah B. Laditka, *Association Between Community Health Center and Rural Health Clinic Presence and County-Level Hospitalization Rates for Ambulatory Care Sensitive Conditions*, BMC Health Servs. Res. 9:134, at 3, 6 (2009), https://link.springer.com/article/10.1186/1472-6963-9-134 (hospitalization rate for ambulatory care sensitive conditions (*e.g.*, asthma, congestive heart failure, diabetes, hypertension, etc.), was 16% lower in CHC counties).

Delayed treatment often means worse outcomes—and untreated behavioral health disorders, diabetes, and hypertension are just the start. *See, e.g.*, Tori DeAngelis, *Mental Illness and Violence: Debunking Myths, Addressing Realities*, Am. Psych. Ass'n, https://www.apa.org/monitor/2021/04/ce-mental-illness (last updated July 11, 2022) (consistent treatment and medication is critical to keep mental health disorders from becoming mental health crises); Sen Li et al., *Diabetes Mellitus and Cause-Specific Mortality: A Population-Based Study*, 43 Diabetes & Metabolism J. 319, 319 (2019), https://doi.org/10.4093/dmj.2018.0060 ("Untreated diabetes leads to multiorgan and systemic injury, including to the heart, kidneys, nerves, and blood vessels, which impair the quality of life and increase the death rate caused by diabetes complications."); Donghao Zhou et al., *Uncontrolled Hypertension Increases Risk of All-Cause and Cardiovascular Disease Mortality in US Adults*, Sci. Reps. 8:9418, at 3 tbl.2 (2018), https://doi.org/10.1038/s41598-018-27377-2 (untreated hypertension led to significantly elevated all-cause, cardiovascular, and stroke-related mortality).

Mortality increases when CHCs close, especially in the disease states most susceptible to screening and intervention. Looking at 3,000 U.S. counties between 2011 and 2019, researchers found that overall mortality increased (3.54 age-adjusted all-cause deaths per 100,000 residents) in

the year after a CHC closed. Sanjay Basu et al., *Impact of Community Health Center Losses on County-Level Mortality: A Natural Experiment in the United States*, *2011–2019*, Health Servs. Res. 60:e14648, at 1 (2025), https://doi.org/10.1111/1475-6773.14648. The effect was worst for cancer-related deaths, which rose by 2.61 deaths per 100,000 residents. *Id.* A different study found a similar effect with HIV risk—more CHC access meant fewer HIV diagnoses, fewer *late* HIV diagnoses, and increased viral suppression. Jessica S. Kiernan et al., *Access to Federally Qualified Health Centers and HIV Outcomes in the US South*, PubMed Cent., at 5–6 (2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC11034789/pdf/nihms-1953573.pdf. Common sense suggests why: when CHCs close, patients miss preventive screenings; when they miss screenings, they are blindsided by late-stage disease leading to critical trips to the emergency department, inpatient stays, and a higher risk of death. *See id.* at 6–7 ("[CHCs] may benefit communities by providing additional sites (and providers) to access HIV prevention, testing, care, and treatment and by addressing cost and insurance-related barriers to accessing these services."); Basu et al., *supra*, at 7 (increased cancer mortality was "consistent with CHCs' role in cancer screening and early detection through services such as mammography referrals and colorectal cancer screening programs").

Those worsening outcomes will increase demand for inpatient and specialty services. A patient who misses primary care may later need admission, oncology care, dialysis, cardiac care, psychiatric care, or surgery. Inpatient care, however, is not a limitless resource.

III. CHA's members are already operating at or near licensed capacity and cannot add beds and/or staff by the time the initiative would take effect.

Hospitals already lack spare licensed capacity for an Initiative-driven demand surge. And they cannot quickly stretch to accept those displaced CHC patients. Two hurdles must be overcome: space and staff. But adding beds in California is no easy task. And even if it were, California's healthcare worker shortage means that hospitals may be unable to meet state-mandated staffing ratios to legally accept the additional patients.

Hospitals cannot add sufficient beds to prepare for CHC patients by the time the Initiative would be effective. Licensed beds do not come online just because demand rises. In California,

hospitals cannot add beds without navigating a field of regulations overseen by multiple agencies. First, they must ask the California Department of Public Health ("CDPH") for permission to build an "addition to an existing facility," increase "licensed bed capacity," or add services. Cal. Code Regs. tit. 22, § 70105(a)(1)–(3).

On top of that, hospitals must contend with the Department of Health Care Access and Information ("HCAI"), which regulates "the construction of, or addition to, any hospital building or the reconstruction or alteration of any hospital building." *Id.* §§ 129750, 129740. On the hospital's dime, HCAI must "review the structural systems and related details, including [an] independent review of the geological data . . . by an engineering geologist" and of the "structural design data . . . by a structural engineer." *Id.* §§ 129765, 129770. And California's Seismic Safety Standards make hospital construction, modification, and addition even more resource intensive. "Under existing law, all hospital buildings providing acute care services in California are required to be fully functional to provide care following an earthquake as of 2030." *Id.* § 130002(a)(2). That laudable goal has a real-world cost, which a 2019 study pegged at $34 to $143 billion by 2030. Benjamin Lee Preston et al., RAND Corp., *Updating the Costs of Compliance for California's Hospital Seismic Safety Standards* 95 (2019), https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3059/RAND_RR3059.pdf. Some portion of those costs are realized every time a hospital touches its physical structure.

Practical considerations govern, too. For example, if the new beds push a hospital to 100 licensed beds or more, then it *also* needs "a pharmacy on the premises licensed by the California Board of Pharmacy." Cal. Code Regs. tit. 22, § 70263(a). So a hospital with 95 beds, facing demand for 105, might max out at 99 because the additional expenditures and regulatory hurdles to add an entire pharmacy on top of ten more beds make the full project not feasible.

Adding physical beds is not the only cost. Hospitals must also add staff to meet the "minimum, specific, and numerical licensed nurse-to-patient ratios" established by CDPH for the exact "licensed nurse classification" and" hospital unit." Cal. Health & Safety Code § 1276.4(a).[2]

[2] These rules govern all but the state's own hospitals: CDPH's regulations do "not replace" the "ratios for hospitals operated by the State Department of State Hospitals," Cal. Health & Safety

This means identifying the right number of "registered nurse[s], licensed vocational nurse[s] and . . . psychiatric technician[s]," Cal. Code Regs. tit. 22, § 70217(a), and spreading them out in the right state-mandated patient-to-nurse ratio across the "critical care unit" (1:2); "labor and delivery suite" (1:2); "postpartum area" (1:4); "combined Labor/Delivery/Postpartum area" (1:3); "pediatric service unit" (1:4); "postanesthesia recovery unit" (1:2); "emergency department" (1:4, plus a triage nurse and a "base radio responder" when appropriate; 1:2 when nurses are handling "critical care patients"; 1:1 when handling "critical trauma patients"); "step-down unit" (1:3); "telemetry unit" (1:4); "medical/surgical care unit[]" (1:5); and "specialty care unit" (1:4), *id.* § 70217(a)(1)–(12).

But that is not currently possible. In California, hospitals regularly struggle to hire new workers to meet state-mandated ratios. Just last week, HCAI stated that more than half of all Californians live in an area with a nursing shortage. Memorandum from Libby Abboyy, Dep. Dir., HCAI, to California Healthcare Workforce Policy Commission 2 tbl.2 (June 15, 2026). That publication confirms HCAI's prior modeling. Extrapolating from 2022 data, HCAI had predicted that only 14 counties would have a surplus of nurses by 2026. *Supply and Demand Modeling for California's Nursing Workforce*, HCAI, https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-californias-nursing-workforce/ (last visited June 17, 2026). That shortage was expected in rural and urban areas alike—with rural counties having more severe *percentage* gaps, *id.* (visualization, sorted by "Gap %"), and urban areas like Los Angeles, Alameda, Orange, and San Francisco Counties suffering the largest *nominal* gaps, *id.* (visualization, sorted by "Supply-Demand Gap"). Sure enough, rural counties like Glenn (-82.9%), Plumas (-62.9%), and San Benito (-61.8%) have the largest percentage shortfalls, but the South Los Angeles Service Planning Area[3] (-6,598) and Alameda (-2,807.3), Orange (-2,468), and San Francisco (1,470) Counties lead the way on total shortfall. Abboyy Mem., *supra*, at 3–5 tbl.3. In other words, rural and urban hospitals alike cannot just add staff to increase licensed capacity. The staff is not there.

Code § 1276.4(j); and CDPH "may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing nurse-to-patient ratios," *id.* § 1276.4(l).

[3] SPA 6 in the memorandum is South Los Angeles. *See Service Planning Area*, Cnty. of L.A. Pub. Health, http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm (last visited June 17, 2026).

This problem is especially acute for behavioral health, an area where CHCs currently lighten much of the hospitals' load. As noted above, CHCs provide behavioral health services that help stabilize patients—not just to prevent crisis, but to help patients live normal lives as functioning members of their communities and families. *See* Nagel et al., *supra*, at 6–7 (CHCs' role in "[h]ealth promotion" includes "maintenance of . . . mental health"). When patients cannot get those services, they land in emergency departments and often require inpatient treatment. "In 2024, patients with behavioral health diagnoses accounted for nearly one third (29%) of all [inpatient] hospitalizations and approximately one eighth (12%) of all ED treat and release visits." *Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics*, HCAI, https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/ (last visited June 16, 2026). Fewer CHCs for preventive psychiatric care means even more demand for hospital psychiatric treatment.

California's newest approach to psychiatric staffing already makes adding licensed capacity difficult. CDPH was ordered to "adopt emergency regulations" setting psychiatric unit-specific staffing ratios in January of this year. Cal. Health & Safety Code § 1276.4(k)(2). Such regulations would govern more than just "[s]taffing standards," but also the way "to determine appropriate staffing based on patient acuity and care needs," and anything else CDPH "deems necessary or relevant to staffing policies." *Id.* § 1276.4(k)(4). The order took effect June 1, requiring one nurse per six adult or five minor patients. Letter from Mandi Posner, Deputy Dir., Cal. Dep't of Pub. Health, to Acute Psychiatric Hospitals (Jan. 26, 2026), https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-26-03.aspx; *see* Cal. Code Regs. tit. 22, § 71215(h).

The state may order some number of staff per patient, but if the staff cannot be found, patients take the hit. Following that June 1 order, hospitals across California were forced to close psychiatric beds. Since June 1, 65 beds have closed statewide, with Kern, Contra Costa, Madera, and San Diego Counties having each lost an average of 15% of their acute psychiatric beds. Ella Ruder, *"Making a Bad Situation Worse": 15% of Psych Beds Lost in 4 California Counties After*

Staffing Rule, Becker's Hosp. Rev. (June 12, 2026), https://www.beckershospitalreview.com/behavioral-health-government-policies/making-a-bad-situation-worse-15-of-psych-beds-lost-in-4-california-counties-after-staffing-rule/. The beds were fine, and the patients needed them—indeed, California was already 2,000 adult psychiatric beds short. *Id.* But, when the calendar flipped to June, putting patients in some beds became unlawful.

And the same primary issue—overcrowding—that makes adding new staff legally necessary makes keeping current staff more challenging. Crowding in the emergency department subjects staff to increased violence and stress, resulting in more burnout and high turnover. Morley et al., *supra*, at 24; Kelen et al., *supra*, at 3. Hospitals will have the impossible task of filling a funnel: as they struggle to add new staff to keep up with mandated ratios, their current staff may be driven away by the same overcrowding that makes more staff necessary.

A lack of licensed capacity has real-world effects: it means that some CHC patients may be turned away by hospitals legally prohibited from treating them. The Initiative imagines infrastructure that does not exist and cannot be brought online in anywhere near the time that would be required if the Initiative were to pass in November and take effect next January. Consider the effects of the psychiatric staffing order again: California hospitals had hired more than 1,100 new licensed nurses before June 1, and yet beds *still closed* due to insufficient staffing. Ruder, *supra*. Now add high-acuity CHC patients dealing with mental health crises and medical emergencies that may have been prevented by the care they get at CHCs. The Initiative risks eliminating one safety-net—CHC care—before the remaining one—hospitals—has any meaningful opportunity to prepare. And allowing the Initiative on the ballot will force hospitals to begin redirecting resources to a problem that can and should be avoided altogether.

CONCLUSION

The public interest weighs against publishing the Initiative. CHCs keep vulnerable Californians connected to primary, preventive, psychiatric, and behavioral health care. Hospitals cannot add the licensed capacity necessary to absorb the demand for services that would predictably follow the Initiative's impact on CHCs. CHA thus urges this Court to grant plaintiffs' motion for preliminary relief.

Dated: June 22, 2026

Respectfully submitted,

JONES DAY

By: */s/ Matthew J. Silveira*

Matthew J. Silveira
msilveira@jonesday.com

Attorneys for Amicus Curiae California Hospital Association