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Study of Potential Impacts from the Attorney General Initiative 25-0008A1

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INTELLIGENCE THAT WORKS

Contents

Executive Summary

This study summarizes the methodology, underlying data, and results of our analyses of federally qualified health centers (FQHCs) and FQHC Look-Alikes in California. We have assessed the financial operations and services provided at FQHCs and other clinics and calculated the financial impact that the proposed ballot measure "Attorney General Initiative 25-0008A1" (Ballot Measure)[1] will have on FQHCs and FQHC Look-Alikes in California as well as its effects on the state's healthcare landscape. This analysis specifically focused on the Ballot Measure's proposed requirement that clinics spend at least 90% of their revenue on program expenses. Importantly, the Ballot Measure's calculation of what can be included in the 90% ratio excludes critical mission related and patient care related expenses. Further, the Ballot Measure requires clinics that fall below the 90% spending threshold to pay an annual penalty equal to the amount that would bring a clinic into compliance with the 90% threshold. Clinics will also pay a registration fee that is meant to cover state expenses related to enforcing the spending requirement and administrative efforts to process, evaluate, and disseminate collected data.[2] We have outlined our key findings below.

- An investigation into the financial situation of FQHCs and Look-Alikes in California details a challenging financial picture, one with the potential to be made significantly worse if clinics incur anticipated penalties from the Ballot Measure.
- Most of the clinic parent organizations (91% or 183 of 202) analyzed do not meet the initiative's arbitrary 90% spend ratio requirement.
- Those organizations could pay $1.7 billion in total penalties in the first year alone – money from the clinics that would be redirected from patient and mission related expenses into a state penalty fund. Clinics would face similarly crippling penalties every year.
- The overwhelming majority of the organizations (88% or 161 out of 183) will have a total negative margin as a result of this measure – putting clinics at risk of closure.
- Organizations at risk of closing were associated with between 1.3 million and 11.7 million patient encounters in 2023 – including up to 7.7 million encounters from Medi-Cal patients.
- The strict 90% ratio would not allow clinics to keep funding in reserves for major capital investments, such as opening new clinics, purchasing new equipment or technologies, investments into value-based care, and preparing for potential public health or other emergencies.
- The Initiative will increase State General Fund costs by more than $1 billion, primarily because displaced patients will be forced to receive care in more costly settings, including county and University of California clinics, and hospital emergency rooms.

[1] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008 [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].
[2] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 3.c [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].

- The measure will increase costs to the State by an additional $19.2 million as the Attorney General and the Department of Public Health will be required to hire 90 full time employee equivalents to enforce the measure.

Background

Community health clinics (CHCs), typically non-profits, provide a variety of medical and community services, especially primary care services, in an outpatient clinic setting regardless of a person's ability to pay.[3] By serving patients with no health insurance, limited financial means, or living in underserved geographic areas, these clinics provide a vulnerable segment of the population with preventive and essential medical care, with the hope of reducing more extreme and expensive medical interventions. The Ballot Measure focuses on FQHCs and FQHC Look-Alikes. FQHCs must adhere to stricter regulatory requirements compared to other clinics due to one of their primary sources of income, federal grants from the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. § 254b).[4] When a clinic receives this funding, it agrees to specific financial, compliance, and reporting requirements meant to ensure that clinics operate efficiently and effectively. FQHCs also receive funding from Medicare and Medi-Cal and agree to additional oversight intended to ensure that "costs are reasonable, necessary, and directly related to patient care" (42 CFR § 413.9).[5] FQHC Look-Alikes meet all of the eligibility requirements of an FQHC but do not receive HRSA grant funding.

The United Healthcare Workers (UHW) union, part of the larger Service Employees International Union (SEIU), filed the Ballot Measure with the hope of qualifying for the 2026 November election. This Measure imposes strict and arbitrary spending requirements on FQHCs and Look-Alikes, with a penalty for any clinic that does not meet this requirement.

An investigation into the financial situation of FQHCs and Look-Alikes in California details a challenging financial picture, one with the potential to be made significantly worse if clinics incur anticipated penalties from the Ballot Measure. The Ballot Measure requires that each Clinic report a "Spend Ratio", which is calculated as the "total amount spent on activities that accomplish each clinic's exempt purposes divided by that clinic's total revenue." If a clinic does not meet a 90% threshold on the Spend Ratio, then the clinic is required to pay a penalty equal to the amount that constitutes the difference between the clinic's expenses and the amount that the clinic would need to spend to meet the 90% threshold.[6]

[3] What is a Community Health Center? - NACHC [https://www.nachc.org/community-health-centers/what-is-a-health-center/].
[4] Federally Qualified Health Center — Centers for Medicare & Medicaid Services: Medicare Learning Network [https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf].
[5] Code of Federal Regulations (CFR) Title 42 § 413.9 [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-A/section-413.9].
[6] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 3 [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].

Summary of Data and Methodology

IRS Form 990 Data

To evaluate the Initiative's financial impact on FQHCs and Look-Alikes in California, we used organization-level data sourced from the Internal Revenue Service (IRS) form 990s, which is a tax form filed by tax-exempt organizations, non-exempt charitable trusts, and section 527 political organizations.[7] The IRS form 990 data is relevant for this analysis because the Initiative requires that the organization's Spend Ratio be calculated using the expenses related to the organization's "exempt purpose." The Initiative requires that clinics use "total program service expenses" from line 4e of Part III and total revenue from line 12 of part I of form 990. The California Primary Care Association (CPCA) collected form 990 data for 202 organizations for 2023 and 2024 and provided it to us for analysis. The data shared by CPCA contains revenue and expense information sourced directly from the form 990s as well as financial metrics derived using form disclosures. We reviewed and confirmed CPCA's calculation of these financial metrics, which included the Spend Ratio, the penalty proposed in the Ballot Measure, and clinics' operating margin/income. We also compared the form 990 data to other publicly available data for the same time period, to ensure that the numbers obtained from the form 990 data were reasonable.

The IRS form 990 is required for most FQHCs and Look-Alikes but has not historically been used to identify "mission-related" expenditures. Line 4e of Part III of the IRS form 990 does not explicitly include all expenses that are necessary in order for the clinics to provide vital medical care, such as community outreach and education, medical devices and technology, state licensing fees, health insurance enrollment assistance, case management, electronic health record systems, and population health software, to name a few. Clinics need to incur these expenses to adequately meet the health care needs of the vulnerable populations it serves. This data was used for this analysis because it was the best available data to estimate the financial impact of the Measure on clinics in California.

Public HCAI Data

We leveraged the California Department of Health Care Access and Information (HCAI) Primary Care Clinic data to identify encounter, revenue, and expense data for the 202 organizations in the form 990 data.[8] The HCAI Primary Care Clinic data includes clinic demographic and descriptive information, income statements, and encounter data. We used this data to assess the Initiative's potential impact on the California healthcare marketplace. The HCAI Primary Care Clinic reporting form, data, and documentation is published by HCAI annually.[9]

[7] The Form 990 is filed annually [https://www.irs.gov/forms-pubs/about-form-990].
[8] California Department of Health Care Access and Information (HCAI) Primary Care Clinic Annual Utilization Data [https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data].
[9] *Id.*

Linking Form 990 and HCAI data

We identified individual clinics from the 2023 HCAI Primary Care Clinic data that are associated with the organizations that submit IRS form 990 data based on the clinic and parent organization names in the HCAI data and the parent organization names in the IRS form 990. Of the 202 organizations identified in the IRS form 990 data, we identified all but six (6) organizations in the HCAI Primary Care Clinic data. In addition, we found eight (8) organizations present in the 2023 data that did not submit any information and were flagged in the data as "non-responsive".[10,11] The 188 organizations that reported data in 2023 relate to 782 individual clinics in the HCAI Primary Care Clinic data. Of these 782 clinics found, 727 (93%) are classified as FQHCs or FQHC Look-Alikes. These 727 clinics represent 90% of all clinics in the 2023 HCAI Primary Care Clinic data that are classified as FQHCs or FQHC Look-Alikes.

Summary of Analyses Performed

We used the IRS form 990 data and HCAI Primary Care Clinic data to complete the analyses outlined below and measure the potential effects of the proposed Ballot Measure.[12]

We sought to determine the impact on clinics by first identifying the number of organizations that would be out of compliance with the Initiative's 90 percent Spend Ratio requirement. We also calculated the penalties that would be assessed on clinics that did not meet the Spend Ratio requirement. Using that information, we determined the financial impact that the Initiative would have on clinics' balance sheet, and their ability to operate. We identified three (3) scenarios in which clinics would potentially close due to the financial burden that the penalties and the overall Initiative would impose on them.

We evaluated the additional impact on the healthcare market in California by identifying the number of encounters, by payer, that would be displaced in the event of clinic closures using the three (3) scenarios in which clinics would potentially close. We also determined the challenges posed to the California healthcare system due to this financial strain and loss of important healthcare infrastructure.

Then, we estimated the fiscal impact on the State. First, we isolated the impact and additional costs that California would incur due to the administration of the provisions. We identified provisions that require increases in the State's bureaucracy, provisions that impose penalties on clinics, and provisions that will increase the costs for other General Fund-supported programs, thereby widening the General Fund deficit. We then enumerated the indirect effect on state General Fund revenues and expenditures.

[10] Community Health Systems Inc., Father Joe's Villages, and San Francisco Community Clinic Consortium cannot be identified in the 2023 HCAI data.

[11] There are eight (8) organizations that are found in the 2023 HCAI Primary Care Clinic data but are found with indication that the organization did not fill out the HCAI form. The organizations are: Anderson Valley Health Center Inc, Behavioral Health Services Inc, Chinatown Service Center, Coppertower Family Medical Center DBA Alexander Valley Healthcare, El Dorado County Community Health, Imperial Beach Community Clinic, Los Angeles Christian Health Centers, and RotaCare Bay Area Inc.

[12] The analysis was completed using the data that was available, so the impact may differ depending on future reporting.

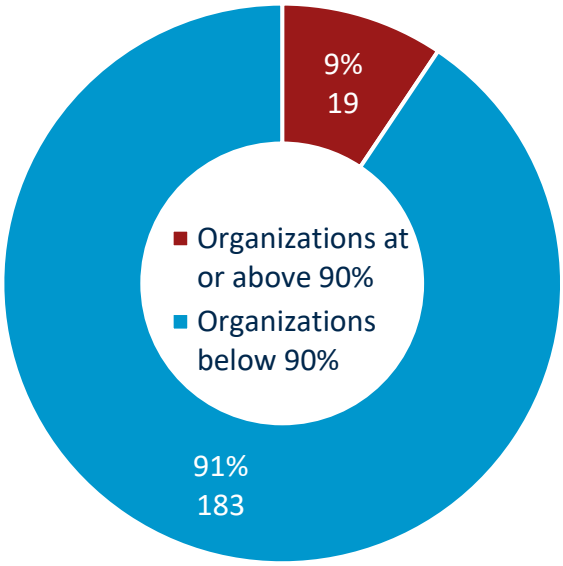
Determine the Impact on Clinics

Spend Ratio and Clinic Compliance

As defined by the Initiative, an organization's Spend Ratio is the total amount spent on activities that accomplish each organization's exempt purpose divided by that organization's total revenue. Using the IRS form 990 data and language in the Initiative, we calculated the Spend Ratio as an organization's total program expenses divided by total revenue. The Initiative requires that organizations have a 90% or greater Spend Ratio, or they will be subject to penalties to bring them into compliance.

As shown in Exhibit 1, we estimated that 183 (91%) of the 202 organizations in the IRS form 990 data would not meet the 90% Spend Ratio requirements. When an organization is out of compliance, it will pay a penalty that reconciles the total program expenses with revenue, so that the total program expenses plus the penalty divided by the revenue is equal to 90%.[13] We estimated that organizations will be asked to pay $1.7 billion in penalties in just the first year. While the Initiative indicates that the penalties will go to the administration of the program, along with funding for workforce training, recruitment, and retention, it is unlikely that all the organizations will be able to pay the penalty. The assessment of $1.7 billion in penalties in the first year alone will have significant implications for clinic operations.[14]

Exhibit 1: Organizations that Meet the 90% Spend Ratio



[13] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 4. [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].
[14] *Id.*

The strict 90% ratio would not allow clinics to keep funding in reserves for major capital investments, such as opening new clinics, purchasing new equipment or technologies, investments in value-based care, and preparing for potential public health or other emergencies. A Spend Ratio threshold that is based on revenue ensures that organizations are unable to save funds over time, because if an organization attempts to reserve part of its revenue for longer term purchases or investments, it will instead be required to pay those funds back to the state in the form of a penalty.

Margin Analysis and Clinics' Ability to Operate

We analyzed the total margin for each organization prior to any penalties, to understand the financial status of each organization. The total margin is a measure of an organization's financial stability and is calculated by subtracting total expenses from total revenue, and dividing the remainder by total revenue.

Total Margin Prior to Initiative

$$\left\{ \frac{(\textit{Total Revenue} - \textit{Total Expenses})}{\textit{Total Revenue}} \right\}$$

The table below shows the total margin for each organization in 10% increments, and also shows the number of organizations that meet the 90% Spend Ratio threshold versus those that do not. Most of the organizations (16 of 19) that meet the Spend Ratio are already operating with a total margin below zero (and all have a margin less than or equal to 10%). The average total margin for organizations that meet the 90% Spend Ratio criteria is negative 9.8%, and the average total margin for organizations that will not meet the 90% Spend Ratio criteria is positive 6.9%. Overall, the average margin of all organizations is 6.0% prior to the Initiative. With a negative margin, it is doubtful that these 16 organizations could continue to meet the Spend Ratio requirement for very long.

Exhibit 2: Organizations that Meet Spend Ratio and Total Penalties by Total Margin[15]

Current Total Margin [2]	Organizations at or above 90%	Organizations below 90%	Total Penalties [4] [5]
Less than -10%	11	6	$18,079,541
-10% to 0%	5	32	$132,960,291
0% to 10%	3	73	$804,902,769
More than 10%	0	72	$721,157,229
Total	**19**	**183**	**$1,677,099,830**

[15] Current Total Margin indicates that the total margin prior to the Initiative is within the ranges listed in the chart. The first number listed in the range relates to a margin that is greater than the number, and the second number relates to a margin that is less than or equal to the number. For example, the range of 0% to 10% includes any clinic that has a total margin that is greater than 0% but less than or equal to 10%.

There are 54 organizations (27%) that are operating with a negative margin prior to the Initiative, of which, 16 will meet the Spend Ratio threshold of 90%. To understand the impact of the Initiative, we then determined what the margin would be for each organization after a penalty is assessed. After the Initiative is in place, the total margin is calculated as the total revenue less total expenses less penalties, divided by total revenue.

Total Margin After Initiative

$$\left\{ \frac{(\textit{Total Revenue} - \textit{Total Expenses} - \textit{Penalties})}{\textit{Total Revenue}} \right\}$$

As previously described, most organizations (all but 19) would be subject to a penalty because of the Initiative. After the penalty, 177 (88%) organizations will have a negative total margin. The Initiative would result in significant financial penalties and cause many clinics to operate in "the red" (with a negative margin) – likely forcing many to shut down.

To estimate the impact on organizations' ability to operate, we identified the number of organizations from the IRS form 990 data (and their corresponding clinics) that would potentially close based on three (3) scenarios: (1) total negative margin of less than -10% after Initiative, (2) total negative margin of less than -20% after Initiative, and (3) total negative margin of less than -30% after Initiative. Based on these scenarios, we have identified the number of organizations that would potentially close under each scenario. Scenario (1) includes the organizations in scenario (2) and (3), and scenario (2) includes the organizations in scenario (3).

Exhibit 3: Potential Clinic Closures by Scenario

Updated Total Margin w/ Penalty	Number of Organizations	Total Penalties
1) Less than -10%	97	$879,818,990
2) Less than -20%	30	$233,461,883
3) Less than -30%	14	$35,456,660

The measure would pose significant cash flow issues for organizations. In fact, 66% (117) of organizations with a negative total income after the penalty will have a negative income that is equal to or greater than $1 million. The average total income for all organizations after penalty, regardless of total margin, is -$4.9 million, but ranges between -$42.1 million and $12.7 million. Even organizations that meet the Spend Ratio have tenuous financial situations, and 84% (16) of the organizations that meet the Spend Ratio already have a negative operating income.

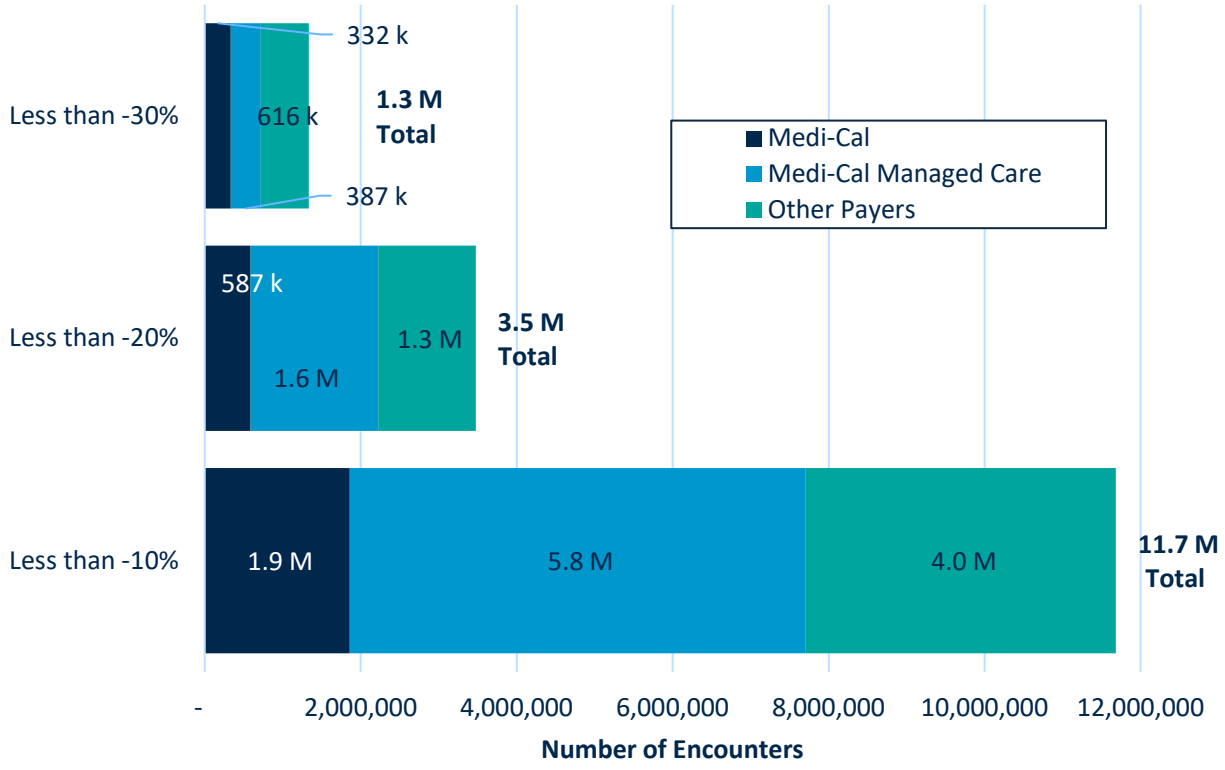
Initiative Impact on California Healthcare Landscape

If implemented, the Initiative could result in many organizations and associated clinic sites closing, which would impact patients' access to essential primary care and healthcare services. This disruption in service will have a ripple effect across the healthcare marketplace in the state. We first assessed the magnitude of patient encounters that would be displaced if organizations were to close under each scenario outlined above. To assess the magnitude of patient encounters that would be displaced, we used HCAI Primary Care Clinic information from 2018 through 2021 to estimate the number of encounters associated with each clinic by payer. This data was not available in the 2022 and 2023 HCAI Primary Care Clinic information due to a new guideline beginning in October 2023, where annual utilization report data must follow the California Health and Human Service Agency's (CHHS) Data De-Identification Guidelines. These guidelines require that any group identified as having a potential risk of re-identification is masked from the dataset.[16] Therefore, we used the prior years of available data to estimate the number of encounters in 2023. Of the 202 organizations analyzed, we were able to estimate the 2023 encounters for 177 organizations (88%). This means that our estimates of displaced encounters are less than the total encounters that would potentially be displaced under each scenario.

Organizations with a margin of negative 10% or less after the Initiative are associated with approximately 11.7 million encounters in 2023. This includes approximately 1.9 million Medi-Cal encounters and approximately 5.8 million Medi-Cal managed care encounters. Organizations associated with a margin of negative 20% or less after the penalty assessed pursuant to the Initiative are associated with approximately 3.5 million encounters in 2023, and organizations associated with a margin of negative 30% or less after the penalty assessed by the Initiative are associated with approximately 1.3 million encounters. Exhibit 4 below includes details on the estimated number of encounters that would be displaced, by payer, based on the closure scenarios outlined previously.

[16] California Department of Health Care Access and Information (HCAI) Primary Care Clinic Annual Utilization Data [https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data].

Exhibit 4: Number of Encounters at Clinics that may Close by Scenario and Payer



As patients are displaced from clinics that cease operations after the Initiative, they will have to seek out healthcare services elsewhere, driving up healthcare expenditures and disrupting patient access to services. For example, when a clinic closes, its patients will move to other places of service, often resulting in more emergency room visits and visits at more expensive care sites. Patients may also start skipping primary care services leading to higher future expenses due to a lack of routine medical care. This disruption in access to primary care services and patient continuity of care will most acutely impact vulnerable Californians who are most likely to use FQHCs and Look-Alikes. Clinic closures will also impact other Californians who may not use them directly. When patients covered under government healthcare services and insurance become more expensive or their services are not reimbursed, the resulting increased costs are shifted to commercial and other patients within the state by medical providers.

Impact on the State

Provisions that Require Increases in the State's Bureaucracy

Attorney General

Section three (3) of the Initiative would assign to the Attorney General the following new duties: (1) draft and issue guidelines governing how clinics report information about their revenues and expenditures, (2) receive and maintain reports submitted by clinics covered by the measure, (3) post the data submitted by clinics on the Department of Justice's website, (4) calculate the Spend Ratio for each clinic and transmit the calculation to the Department of Public Health (DPH), (5) develop, adopt, publish, and update a schedule of additional administrative fees to be paid by covered clinics, (6) review the clinics' compliance with the reporting requirements of the Initiative, and (7) impose sanctions on clinics for non-compliance. The Initiative also authorizes, but does not require, the Attorney General to audit the clinics' books, as well as the books of contractors and related parties, to ensure the accuracy of their reporting. Such audits should be considered mandatory because without them, the Attorney General would not be able to secure the clinics' compliance with the measure.[17]

As shown in Appendix 1, Section three (3) of the Initiative would require the Attorney General to hire approximately 35 additional State employees, with an estimated cost of $6.5 million. The Initiative requires clinics to pay an additional annual registration fee sufficient to cover the costs of administering the Initiative.[18]

Section four (4) of the Initiative requires the Attorney General to receive appeals submitted by clinics disputing the Department of Public Health's findings that they are not in compliance with their Spend Ratio targets. Although the initiative does not require the Attorney General to act on the appeals it receives, it is reasonable to assume that the initiative's proponents expect the Attorney General to consider the appeals and share its findings and conclusions with the Department of Public Health.

As shown in Appendix 1, the workload associated with processing appeals would require the Attorney General to hire an additional three (3) State employees, at an estimated cost of $750,000. Fees imposed on clinics would be sufficient to cover these costs as well.

[17] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 3.f [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].
[18] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 3.c [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].

Department of Public Health

Section four (4) of the Initiative requires the Department of Public Health ("the Department") to complete the following tasks each year: (1) assess penalties on clinics that fail to meet or exceed their Spend Ratio target, (2) maintain the Special Deposit Fund that receives penalty revenues, (3) reach agreement with clinics regarding the allowable use of any money reimbursed from the Fund, and (4) receive, consider, and act on requests submitted by clinics seeking waivers from the targets. Section four (4) also authorizes, but does not require, the Department to audit clinics for compliance with any spending plans it agrees to, and to recoup funds from clinics that fail to comply with these plans. Such audits should be considered mandatory because without them, the Department would not be able to obtain compliance with approved spending plans.[19]

As shown in Appendix 1, the Initiative would require the Department to hire approximately 35 additional State employees, with an estimated cost of $7.3 million. The Initiative authorizes the Department to offset the staffing costs with revenues from the fees collected from, and penalties imposed on, clinics. It is possible that the Initiative will cause some of the Department of Public Health's staff to reorganize, as non-profit operators will be less likely to start new clinics. Staff from the licensing team may be able to move to support this Initiative. [20]

Section four (4) of the Initiative also requires the Department to receive and adjudicate appeals submitted by clinics disputing its findings that they are not in compliance with their Spend Ratio targets. We estimate that the State will need to hire 20 additional employees to carry out these duties, with an annual cost to the General Fund of approximately $4.6 million. More detail on this estimate can be found in Appendix 1.

The Initiative authorizes the Department to offset the staffing costs with revenues from the fees collected from, and penalties imposed on, clinics.

Exhibit 5 summarizes the increase in the State's bureaucracy needed to administer the Measure.

[19] The California "Clinic Funding Accountability and Transparency Act"
Ballot Initiative No. 25-0008, § 3.f [https://oag.ca.gov/system/files/initiatives/pdfs/25-0008A1%20%28%26quot%3BClinic%20Funding%20Accountability%20and%20Transparency%20Act%26quot%3B%29.pdf].

[20] We understand that the Department currently has a large backlog of licensing applications awaiting review and approval. Intermittent clinic applications routinely face 8 to 9 month delays due to the department's multi-step enrollment process. While reimbursement is retroactive, unclear guidance and long wait times create financial strain for health centers unable to cover months of unreimbursed care. Additionally, retroactive PPS rates may be subject to adjustment if the approval process is prolonged, increasing financial risk and slowing expansion into underserved areas.

Exhibit 5: Overall Impact on State's Bureaucracy

Organization within State	Number of Employees	Total Fiscal Impact	Net Impact
Attorney General	38	$7.25 million	$0
Department of Public Health	55	$11.90 million	$0
Total	**93**	**$19.15 million**	**$0**

Provisions that Impose Sanctions on Clinics

Section three (3) of the Initiative authorizes the Attorney General to impose sanctions on clinics that do not comply with the Initiative's reporting requirements. The measure does not direct the proceeds from these sanctions, if any, to a specific fund. We estimate that proceeds from these sanctions will be minimal, as clinics are expected to comply with the reporting requirements.

Section four (4) of the Initiative directs the Department of Public Health to impose an administrative penalty on clinics that fail to achieve their minimum Spend Ratios. The revenue from these penalties, if any, would be deposited in the Spend Ratio Penalty Account within the Special Deposit Fund established pursuant to Section 16370 of the Government Code.[21] Any funds deposited in the Account could be used for the following purposes, which are listed in priority order:

1. To fund the activities that Section four (4) assigns to the Department of Public Health,
2. To reimburse clinics that paid the penalties, provided the clinics come into compliance with their approved minimum Spend Ratio targets and reach agreement with the Department of Public Health regarding how the reimbursements will be spent, and
3. To support legislative initiatives funding clinical worker training, recruitment, and retention.

Initially, clinics will incur penalties in the high hundreds of millions of dollars because it will be impossible for them to manage their financial affairs in such a way as to ensure compliance with their approved minimum Spend Ratios. A clinic will not know what its annual total revenue will be until one-to-two years after its fiscal year ends, when the Department of Public Health has completed the reconciliation process, but the clinic will incur operating costs throughout the year. If a clinic's good-faith estimate of its annual revenue proves to be too low, it may find itself out of compliance with its approved minimum Spend Ratio and subject to penalty, even though its firm intention was to achieve compliance.

[21] CA Govt Code § 16370 (2024). [https://law.justia.com/codes/california/2009/gov/16370-16377.html]

It is not possible to determine how much money will be left for legislative initiatives because there is no way to predict with certainty (1) how many clinics will choose to incur the penalty, rather than satisfy the Ratio requirement or close their doors, and (2) how many clinics that opt not to absorb the penalty or close their doors will be successful in recouping a portion of the penalties they incurred by, if feasible, coming into compliance with the spending target at a later date and reaching agreement with the Department of Public Health as to how the recouped funds should be spent.

We estimate that the Initiative will yield negligible revenue for legislative initiatives. Those clinics that are able to operate successfully within the constraints imposed by the Initiative will have a powerful incentive to comply with their approved minimum Spend Ratio. While the cost of compliance is roughly equal to the cost of paying the penalty, compliance will allow the clinic to retain control over how it spends its revenue.

As such, there is likely to be no significant fiscal impact from the Measure's penalty provision on the State General Fund, and no material long-term impact on the Special Deposit Fund, because penalty revenues will be mostly offset by the cost of (1) reimbursing State departments for their administrative expenses, and (2) refunding amounts the clinics paid as penalties.

Provisions that Increase General Fund Costs and the General Fund Deficit

The Initiative will increase State General Fund costs by more than $1 billion through at least four (4) channels.

1. Increased General Fund Costs Due to Higher PPS Reimbursement Rates

State General Fund costs will increase due to higher Prospective Payment System (PPS) reimbursement rates for Medi-Cal. FQHCs are reimbursed by Medi-Cal based on a PPS rate that considers the scope of services at the FQHC[22]. The increased expenditures that the Initiative forces on clinics, together with the costs of the additional registration fees they incur, will give clinics a sound basis for seeking scope-of-service changes that will result in higher PPS rates. Because the State's Medi-Cal program pays for a portion of clinic reimbursements, the Initiative will increase General Fund costs. We estimate that the magnitude of this increase will be more than $100 million.

Exhibit 6 illustrates the potential impact on the State General Fund of the increase in PPS reimbursement rates that the Initiative is likely to bring about. This analysis assumes that after the Initiative takes effect, 105 clinics will continue to operate by increasing their qualifying expenses to the required levels (Scenario 1, clinics with a margin of negative 10% or less close their doors). It also assumes that these clinics can obtain scope-of-service increases sufficient to offset two-thirds of the expenditure increase. The resulting increase in State General Fund costs initially would be approximately $123 million, as the exhibit shows.

[22] Medicaid and CHIP Payment and Access Commission (MacPac). "Medicaid Payment Policy for Federally Qualified Health Centers" {https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf}.

Exhibit 6: Potential Initial Impact of Higher PPS Reimbursement Rates on State General Fund Costs

Formula	Assumption	Impact
[A]	Estimated Spend Shortfall based on current revenues	$1.68 billion
[B]	Shortfall associated with 97 clinics that will close their doors, due to their inability to operate under the Initiative (Scenario 1)	$879.82 million
[C] = [A] – [B]	*Shortfall associated with 105 clinics that are able to continue operating*	*$797.28 million*
[D]	Shortfall recouped through scope-of-service changes resulting in increased PPS reimbursement rates (assumption)	67%
[D] = [C] x [D]	*Amount of shortfall recouped through higher PPS reimbursement rates*	*$534.2 million*
[E]	General Fund Share of Medi-Cal costs[23]	23%
[F] = [D] x [E]	*Increased General Fund costs due to higher PPS reimbursement rates*	*$ 122.9 million*

Exhibit 6 captures only the initial impact of higher PPS reimbursement rates on the state's General Fund. Because the Initiative establishes the Spend Ratio based on a clinic's revenues, rather than on its expenses, 90% of any revenue increase resulting from higher PPS reimbursement rates must also be used for so-called "mission-driven expenses." Consequently, the initial increase in PPS reimbursement rates will not close even two-thirds of the clinics' Spend Ratio shortfall, and the clinics will seek further scope-of-services changes and increased PPS reimbursement rates, the additional revenue from which will push their required expenditures still higher. Thus, Exhibit 6 underestimates the full impact of higher PPS reimbursement rates on the State General Fund in this example.

2. Increased General Fund Costs Due to Patient Displacement

Costs for the General Fund will also increase as patients shift to providers with already established higher PPS rates. As noted previously, some clinics may cease operations under the Initiative because they will not be permitted to retain enough revenue to cover their operating costs and maintain their facilities and equipment. These clinics will no longer be able to meet the health care needs of the patients they currently serve, causing patients to go elsewhere for needed services.

This shift will have significant implications for the State's General Fund because 67% of patients currently served by community clinics and health centers are supported by Medi-Cal.[24] Approximately 23% of the clinics' reimbursements for serving these patients comes from the State's General Fund.[25]

[23] California Health and Human Services. "California State Budget – 2025-26". {https://ebudget.ca.gov/2025-26/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf}.
[24] California Primary Care Association. Data and Reports - "2025 California State Profile of Community Clinics and Health Centers". {https://www.cpca.org/CPCA/About/Publications_and_Reports/CHC_Data/CPCA/About/CHC_Data.aspx}
[25] California Department of Finance. "California State Budget: Health and Human Services – 2025-26". {https://ebudget.ca.gov/2025-26/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf}.

A relatively small number of displaced patients will be able to find other non-profit health clinics that continue to operate under the Initiative and have sufficient excess capacity to serve them. These are likely to be county-run clinics with above-average PPS rates.

Patients that are not able to obtain services from other non-profit clinics, either because they do not search for a replacement clinic or because they cannot find one in their area with excess capacity, will seek the services they need from county-operated clinics and hospital emergency rooms, where the cost of treatment is significantly higher than it is in non-profit clinics. We estimate that if the Initiative had been in effect for fiscal year 2023, between 1.3 million and 11.6 million encounters would have been diverted from the clinics that discontinued operations to other state-funded providers, causing a significant increase in the cost of care paid for by the General Fund.

Exhibit 7 below illustrates the potential annual increase in General Fund costs for the caseload that would be displaced from those clinics that discontinue operations in one county – Los Angeles – that accounts for 25% of the State's population.[26] Because General Fund Revenues currently do not cover General Fund costs, these increased costs will increase the State's General Fund Deficit.

Exhibit 7: Cost Impact to State Based on Closures (LA County Example)

Formula	Current Reimbursement Rates (Unweighted)	
[A]	LA County Clinics	$976.72
[B]	All Clinics (Excluding LA County Clinics)	$284.41
[C] = [A] – [B]	*Difference in Reimbursement Rate*	*$692.31*
	Displaced Encounters	
[D]	Encounters at Clinics that Close (-10% Threshold)	11.6 million
[E]	Percent of Encounters Related to LA County	25%
[F] = [D] x [E]	*Displaced Encounters in LA County*	*2.9 million*
	Cost Impact due to LA County Closures	
[G] = [C] x [F]	*Increased Costs*	*$2.0 billion*
[H]	General Fund Share of Costs[27]	23%
[I]	Portion of Increased Costs Associated with Medi-Cal Patients (assumption)	67%
[J] = [G] x [H] x [I]	*Increased General Fund costs*	*$309 million*

[26] State of California, Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2024 and 2025. Sacramento, California, May 2025. {https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Demographics/Documents/E-1_2025_InternetVersion.xlsx}.
[27] California Department of Finance. "California State Budget: Health and Human Services – 2025-26". {https://ebudget.ca.gov/2025-26/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf}.

3. Increased General Fund Costs to Support the University of California (UC)

General Fund costs may increase due to the higher operating expenses incurred by clinics operated by the University of California. The UC Look-Alike clinics, which are partially supported by the General Fund, are likely subject to the Initiative's provisions.[28,29] As a result of the Initiative, the UC system will need additional staffing to (1) prepare reports that satisfy the AG's requirements, (2) prepare waiver requests for submission to the California Department of Public Health (CDPH), and (3) prepare appeals to penalties that the CDPH imposes. The cost of this additional staffing, together with the cost of the additional annual registration fees and the non-recoverable portion of the penalties paid to the Spend Ratio Penalty Account, will put additional pressure on UC's resources and cause it to seek additional funding from the State. If the State chooses to insulate students from higher fees by increasing State support for UC, the cost to the General Fund will increase by an unknown amount.

4. Increased General Fund Costs to Support State Courts

The Initiative would also increase General Fund costs by increasing the resources needed to support the State court system. The Initiative would add new potential crimes which the state would need to investigate and would create new causes of action that enable private parties to bring suit in State courts. Provisions in the Initiative will result in a minor increase in the courts' operating costs, which are partially funded by the General Fund.

[28] Most of the funding for the clinics comes from UC students in the form of insurance premiums (Student Health Insurance Plan), fees, and copayments. The campus or UC's Office of the President subsidizes shortfalls at the clinics and provides support for clinic infrastructure, mental health expansion, and other new initiatives. Some of this money comes from the State General Fund through either the annual budget bill or special legislation.

[29] University of California, Graduate, Undergraduate, and Equity Affairs. "Equity in Mental Health Funding Plan 2021–2025" {https://www.ucop.edu/student-equity-affairs/programs-and-initiatives/equity-funding-plan.pdf}.

Appendix 1: Staffing Required to Administer the Initiative

Note: These estimates are informed by the Department of Public Health analysis of AB 1113, as amended on April 10, 2025 and September 8, 2025.

Assumptions:

- Despite the 12–24-month interval between when an FQHC can determine its expenditures for the year and when the reconciliation process ends and it knows its revenues for the year, the initiative can be implemented without causing this element of California's health care system serving patients with incomes below the poverty line to implode.
- There are approximately 2,000 federally qualified health centers, parent organizations, or FQHC "look-alikes" in California to which this measure would potentially apply.
- There are no federal funds available to cover the increased administrative costs since this workload is not federally required.
- None of the workload associated with the initiative can be absorbed by current staffing at the Department of Justice or the CDPH.
- The Attorney General and CDPH will need to promulgate regulations for multiple provisions of this measure.
- The Attorney General's Office does not currently have the internal resources to audit or operate the initiative's requirements.
- There is annual workload for determining the Spend Ratio and auditing workload every three (3) years (approximately 650-700 clinics per year).
- The CDPH will need staffing to process waiver requests.
- There is a double-appeal process to both CDPH and the Attorney General for clinics appealing the determination and assessment by CDPH.

California Attorney General/Department of Justice Workload

- Annual Calculation of Mission Spend Ratio – **12 positions ($1,946,000)**
    - Assumes each annual calculation will require approximately ten (10) hours of staff time to review and process, using a mix of Associate Governmental Program Analysts (AGPA) and Staff Services Manager (SSM) staff
- Audits of FQHCs and potentially related parties and contractors – **15 positions ($3,000,000)**
    - Assumes each audit will require approximately 40 hours, using a mix of Auditor I, Associate Management Auditor and Sr. Management Auditor positions
- Management & Administrative Support of Annual Filing and Audit Workload – **Three (3) positions ($600,000)**
    - Assume a SSM III, Career Executive Assignment (CEA) (B), and AGPA
- Drafting of regulation packages for calculation of mission-spend ratio methodology; sanction authority and levels for failure to report mission spend ratio requirements – **Five (5) positions ($1,000,000)**
    - Assumes an Attorney III, SSM III, and three (3) AGPA

- **Review and comment on appeals received from clinics -- Three (3) positions ($750,000)**
    - Assumes two (2) Attorney III and one (1) AGPA

California Department of Public Health Workload

- Meet with clinics to determine compliance with clinics plan to meet annual 90% mission spend ratio **– Six (6) positions ($1,200,000)**
    - Assumes Health Program Manager (HPM) II and five AGPA
- Draft regulations to (1) assess mission spend ratio sanctions and penalties, and (2) handle waiver requests – **Five (5) positions ($1,000,000)**
    - Assumes Attorney III, SSM III and three (3) AGPA
- Review and approval of FQHC waiver requests – **three (3) positions ($600,000)**
    - Assumes HPM I and two (2) AGPA
- Audit clinics for compliance with plans to meet mission spend ratio requirements - **15 positions ($3,000,000)**
    - Assumes each audit requires approximately 40 hours to perform, and is based on a mix of Auditor I, Associate Management Auditor and Sr. Management Auditor positions
- Process appeals regarding Spend Ratio determination and assessment of administrative penalty (CDPH) – **Six (6) positions ($1,500,000)**
    - Assumes four (4) Attorney III and two (2) AGPA
- Process appeals received from FQHC and issue decisions within 60 days – **12 positions ($3,000,000)**
    - Assumes eight (8) Attorney/Hearing Officers and four (4) AGPA
- Audit & Investigation staff (Financial Review/Outpatient Division) for scope of services review and workload – **eight (8) positions ($1,600,000)**
    - Assumes one (1) Sr. Management Auditor, three (3) Associate Management Auditor, three (3) HPSM, and one (1) AGPA

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This study was prepared at the direction of the California Primary Care Association.