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THIRD READING

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Bill No: SB 65  
Author: Skinner (D), et al.  
Amended: 4/15/21  
Vote: 21

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SENATE HEALTH COMMITTEE: 11-0, 4/14/21

AYES: Pan, Melendez, Eggman, Gonzalez, Grove, Hurtado, Leyva, Limón, Roth,  
Rubio, Wiener

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/20/21

AYES: Portantino, Bradford, Kamlager, Laird, Wieckowski  
NOES: Bates, Jones

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**SUBJECT:** Maternal care and services

**SOURCE:** Black Women for Wellness Action Project  
California Nurse Midwife Association  
March of Dimes  
NARAL Pro-Choice California  
National Health Law Program  
Western Center on Law and Poverty

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**DIGEST:** This bill establishes a comprehensive program to improve maternal and infant outcomes: (1) requires state and local investigating, tracking reviewing and reporting of maternal and infant deaths throughout the state; (2) enacts the Midwifery Workforce Training Act to increase the number of students educated and trained as certified nurse midwives and midwives prepared for service in specified neighborhoods and communities; (3) increases postpartum Medi-Cal coverage from 60 days to one year; (4) requires Medi-Cal coverage for doulas; (5) enhances Cal WORKS benefits; and (6) creates a guaranteed income pilot.

**ANALYSIS:**

Existing law:

- 1) Establishes the California Department of Public Health (CDPH) to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health and licensing and certification of health facilities, as specified. Requires CDPH to maintain a program of maternal and child health. Requires CDPH to develop a plan to identify causes of infant mortality and morbidity in California and to study recommendations on the reduction of infant mortality and morbidity in California. Requires CDPH to track and publish data on severe maternal morbidity and on pregnancy-related deaths, as specified. [HSC §131050, 123225, 123650, and 123630.4]
- 2) Requires each county board of supervisors to appoint a local health officer (LHO). Requires LHOs to enforce and observe orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters, orders prescribed by CDPH, and statutes relating to public health. [HSC §101000 and §101030]
- 3) Establishes the Office of Statewide Health Planning and Development (OSHPD) to, among other functions, collect, analyze, and publish data about healthcare workforce and health professional training, identify areas of health workforce shortages, and provide scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need. Establishes the Health Professions Education Foundation (HPEF) within the OSHPD to, among other functions, develop criteria for evaluating applicants for various scholarships and loans. [HSC §127750, et seq. and 128335]
- 4) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage. Makes an individual eligible for Medi-Cal, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. [WIC §14000, et seq., 1400.18, and 15840]
- 5) Establishes the federal Temporary Assistance for Needy Families (TANF) program, which permits states to implement the program under a state plan. Establishes in state law the CalWORKs program to provide cash assistance and other social services for low-income families through TANF. Under

CalWORKs, each county provides assistance through a combination of state, county, and federal TANF funds. [42 USC 601 et seq. and WIC 11120 et seq.]

- 6) Prohibits a pregnant person for whom it has been medically verified that the pregnancy impairs the person's ability to be regularly employed or participate in welfare-to-work activities or the county has determined that, at that time, participation will not readily lead to employment or that a training activity is not appropriate, from being required to participate in Welfare to Work. If a pregnant person is unable to secure this medical verification, but is otherwise eligible for an exemption from welfare-to-work requirements under this section, including good cause for temporary illness related to the pregnancy, the pregnant person shall be exempt from participation. [WIC 11320.3. (b)(7)]
- 7) Requires, if a family does not include a needy child qualified for aid, CalWORKs aid to be paid to a pregnant child who is 18 years of age or younger at any time after verification of pregnancy in the amount that would otherwise be paid to one person if the pregnant child and the child, if born, would have qualified for CalWORKs aid. Requires verification of pregnancy as a condition of eligibility for aid. [WIC 11450(b)(1)]
- 8) Requires, if a family does not include a needy child qualified for aid, CalWORKs aid to be paid to a pregnant person for the month in which the birth is anticipated and for the six-month period immediately prior to the month in which the birth is anticipated in the amount that would otherwise be paid to one person, as specified, if the pregnant person and child, if born, would have qualified for aid. Requires verification of pregnancy as a condition of eligibility for aid under this subdivision. [WIC 11450(b)(2)]
- 9) Requires \$47 per month to be paid to a pregnant person qualified for CalWORKs aid to meet special needs resulting from pregnancy if the pregnant person and child, if born, would have qualified for aid. [WIC 11450(c)]
- 10) Limits CalWORKs temporary shelter assistance and permanent housing assistance to 16 cumulative calendar days of temporary assistance and one payment of permanent assistance every 12 months. [WIC 11450(3)(E)(1)]

This bill:

*California Pregnancy-Associated Review Committee*

- 1) Establishes the California Pregnancy-Associated Review Committee (CPARC) within CDPH to continuously engage in the comprehensive, regular, and uniform review and reporting of maternal deaths throughout the state. Requires

CDPH, in collaboration with the designated state perinatal quality collaborative, to oversee CPARC. Permits CPARC to incorporate the membership of California Pregnancy-Associated Mortality Review Committee (CA-PAMR), as it existed on December 31, 2021. Specifies the purposes of CPARC.

- 2) Requires CPARC investigations of maternal deaths to include, voluntary interviews with specified family members and the medical team, as specified, in addition to reviewing medical records, death certificates, and other pertinent reports.
- 3) Requires CPARC to publish its findings to the public every three years as part of the publication of data on severe maternal morbidity under existing law, and requires the report to also include recommendations on how to prevent severe maternal morbidity and maternal mortality and how to reduce racial disparities.
- 4) Requires CPARC to be composed of a minimum of nine members, and requires members to be comprised of multidisciplinary personnel in the field of maternal mortality and morbidity, data analysis in maternal health, women's health, clinicians in maternal health, and representatives from various public health entities, as specified. Requires CPARC to prioritize for membership members who are representative of the diversity and geographic locations of the pregnant people in populations with disproportionately high occurrences of maternal mortality and morbidity. Requires the Public Health Officer (PHO) to appoint a maternal mortality expert to be a member of CPARC as the chair, and requires the chair to appoint the other members of the committee, as specified.
- 5) Permits CPARC to create subcommittees, as needed, to carry out its duties, and to request from any state department, division, commission, local health department, or other agency of the state or political subdivision, or any public authority, as well as hospitals, birthing facilities, medical examiners, coroners, coroner physicians, and any other facility or individual providing services associated with maternal mortality, and requires those individuals and entities to provide information that will help CPARC to properly carry out its functions, powers, and duties, as specified.
- 6) Requires all proceedings and activities of CPARC, all opinions of its members that are formed as a result of its proceedings and activities, and all records obtained, created, or maintained by CPARC, including written reports and records of interviews or oral statements, to be confidential and to not be subject to public inspection, discovery, subpoena, or introduction into evidence

in any civil, criminal, legislative, or other proceeding. Prohibits CPARC from disclosing any personally identifiable information to the public, or include any personally identifiable information in a case summary or any report.

- 7) Prohibits CPARC members from being questioned in any civil, criminal, legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of CPARC. Specifies that nothing in this bill prohibits a CPARC member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independently of the member's participation on the committee, or as an expert witness in maternal death cases unrelated to their case review as a CPARC member.
- 8) Specifies that this bill does not prohibit CPARC from publishing, or from otherwise making available for public inspection, statistical compilations or reports that are based on confidential information, provided that those compilations and reports do not contain personally identifying information or other information that could be used to ultimately identify the individuals concerned. Requires CPARC to utilize standard public health reporting practices for accurate dissemination of these data elements, especially in regard to the reporting of small numbers so as to inadvertently risk a breach of confidentiality or other disclosure.

#### *Local Fetal and Infant Mortality Review*

- 9) Requires each county to annually report infant deaths to the local health department (LHD). Requires a LHD to establish a Fetal and Infant Mortality Review (FIMR) committee to investigate infant deaths to prevent fetal and infant death if the county has five or more infant deaths in a single year or the county has a death rate that is higher than the state's death rate for two consecutive years. Specifies the duties that LHDs that participate in FIMR to conduct, including to annually investigate, track, and review a minimum of 20% of the county's cases of term infants (36 weeks or more of gestation) who were born following labor with the outcome of intrapartum stillbirth, early neonatal death, or postneonatal death, focusing on demographic groups that are disproportionately impacted by infant death. Requires a county that has less than five deaths in a year to investigate at least one death.
- 10) Requires counties, hospitals, birthing centers, and state entities to provide to local public health agencies death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records, and any other information that will help the local public health agency conduct the fetal and

infant mortality review within 30 days of a request made in writing by a local public health agency.

*Midwifery Workforce Training Act*

- 11) Requires OSHPD to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives to increase the number of students receiving quality education and training as a certified nurse-midwife or a licensed midwife.
- 12) Requires OSHPD to only contract with programs that train certified nurse-midwives and programs that train licensed midwives that, at minimum, include a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and that are organized to prepare program graduates for service in those neighborhoods and communities.
- 13) Requires OSHPD to adopt standards and regulations necessary to carry out this bill, and permits OSHPD to accept those standards established by the licensing and regulatory bodies governing certified nurse-midwives and licensed midwives.
- 14) Permits OSHPD to pay contracted programs that train certified nurse-midwives and programs that train licensed midwives in an amount calculated based on a single per-student capitation formula, or through another method, in order to cover innovative special program costs.
- 15) Permits funds appropriated to OSHPD for purposes of this bill to be used to develop new programs, expand existing programs, or support current programs.

*Postpartum Medi-Cal Coverage*

- 16) Makes an individual eligible for Medi-Cal, as though the individual was pregnant, for all pregnancy-related and postpartum services for a total of 12 months after the end of the pregnancy (instead of 60 days after pregnancy).
- 17) Requires the additional ten months of Medi-Cal coverage to be implemented only to the extent that any necessary federal approvals have been obtained and federal financial participation is available. Requires DHCS, in the first quarter of 2022, to seek any necessary federal approvals to provide for implementation and any state plan amendments necessary for services provided after the end of the 60-day postpartum period in existing law.

*Medi-Cal Coverage for Doulas*

- 18) Makes full-spectrum doula care a covered benefit under Medi-Cal. Requires any Medi-Cal beneficiary who is pregnant as of July 1, 2023, to be entitled to full-spectrum doula care provided by a doula or a community-based doula group.
- 19) Requires a pregnant person, for a pregnancy that is carried to term, to be eligible for at least four appointments during the prenatal period, continuous support during labor and delivery, and at least eight appointments during the postpartum period. Requires doula care to be available to any Medi-Cal beneficiary without prior authorization or cost-sharing.
- 20) Requires DHCS to develop multiple payment and billing options for doula care and to ensure payment within 30 days of submitting a claim for reimbursement, an individual doula be able to obtain a National Provider Identifier number and be directly reimbursed, and a community-based doula group be able to obtain reimbursement for any doula working as part of their group, as specified.
- 21) Requires doulas be paid for full-spectrum doula care. Requires DHCS and Medi-Cal managed care (MCMC) plans, in setting reimbursement rates for doula care, to take into consideration the rate for any paid, community-based doula pilot programs serving the Medi-Cal population in the prior five years, the cost of living in the county, and the sustainable living wage, as calculated in the county.
- 22) Requires presence at a stillbirth to be reimbursed at the same rate as presence at a labor and delivery resulting in a live birth. Requires postpartum services to also be covered for a stillbirth. Requires a separate reimbursement for presence during miscarriage or abortion.
- 23) Requires DHCS and MCMC plans to separately reimburse for each prenatal and postpartum appointment, and requires separate reimbursement for administrative costs, including travel costs. Requires DHCS to make efforts to revisit the reimbursement rate as necessary to account for inflation, cost of living adjustments, and other factors.
- 24) Requires DHCS to establish a centralized registry listing any doula who is available to take on new clients, as specified. Requires the registry to align with existing Medi-Cal provider directory requirements.

- 25) Requires MCMC plans in each county to provide information about the availability of doula care in their materials and notices on reproductive and sexual health, family planning, pregnancy, and prenatal care, as specified. Requires MCMC plans to inform all pregnant and postpartum enrollees at each prenatal and postpartum appointment about the availability of doula care, the benefits of doula care, that doula care is available in addition to other prenatal and postpartum care, and how to obtain a doula.
- 26) Requires DHCS to convene a doula advisory board, which is required to decide on a list of core competencies required for doulas who are authorized to be reimbursed under the Medi-Cal program. Requires the board to reconvene, as deemed necessary by DHCS, at regular intervals, but no less than once every five years. Specifies certain core competencies that are required for reimbursement.
- 27) Requires at least two-thirds of the membership of the board to be composed of practicing doulas who are providing doula care to Medi-Cal beneficiaries, as specified. Requires the board to include at least one obstetrician-gynecologist.
- 28) Requires doulas, in order to be reimbursed under the Medi-Cal program, to provide documentation that they have met the core competencies specified by the board. Permits the board to also create alternative ways to meet the core competencies, such as by providing documentation of certification through another doula certification program that meets the required core competencies. Requires a doula who has met the core competencies set by the board to receive a certificate of completion.
- 29) Requires DHCS to work with outside entities to make trainings available at no cost that meet the core competencies to people who wish to become doulas who are from communities experiencing the highest-burden of birth disparities in the state, including people who are low income, people of color, people from and working in rural communities, and people who speak a language other than English, who wish to become doulas, as specified.

#### *Human Services Provisions*

- 30) Eliminates the mandatory requirement to work or participate in welfare-to-work for pregnant people (unless exempted) and makes participation voluntary.
- 31) Begins aid for pregnant people based on the date of application rather than after the pregnancy is verified. Increases the pregnancy supplemental payment under the CalWORKS program from \$47 to \$82 per month, and indexes this



amount every year. Deletes the limitation on temporary and permanent homeless assistance for households with a pregnant individual.

- 32) Establishes the California Guaranteed Income Pilot for Pregnant People and Infants (CalGIPPI) as a three-year pilot program to test the capacity of the CalWORKs program to serve as a distribution point for monthly guaranteed income payments to pregnant people and parents or relative caretakers of a child less than 24 months of age, with the goal of reducing prenatal and postnatal death and improving short- and long-term health outcomes. Requires the CalGIPPI pilot to commence from the start date of the monthly guaranteed income payments.
- 33) Prohibits gross income from including monetary benefits provided to pregnant and postpartum people pursuant to 32) above. Prohibits monetary benefits provided to pregnant and postpartum people pursuant to 32) above from being considered earned income for purposes of eligibility for the California Earned Income Tax Credit.

### **Comments**

*Author's statement.* According to the author, the United States is failing birthing people and babies – particularly women and babies of color. More birthing people and babies die in this country than in any other high-income countries– and many of these deaths are preventable. This bill takes a comprehensive approach to improve outcomes for birthing parents and babies by closing racial disparities in maternal and infant death and near-death experiences. It accomplishes this by requiring comprehensive investigations into maternal and infant mortality and morbidity, improving data collection and research on socio-economic factors that contribute to negative birth outcomes, expanding postpartum health care for parents and babies, and improving access to health options like doulas and midwives which have been proven to improve birthing outcomes for women and babies of color.

NOTE: Please see the Health Committee and Human Services Committee analysis for full background discussion on this bill.

**FISCAL EFFECT:** Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, Senate Budget Committee estimates the Medi-Cal costs of this bill to be \$9 million annually. Other provisions can only be broadly estimated to be in the multi-millions of dollars in cost pressures to the General Fund and other possible other sources.

**SUPPORT:** (Verified 5/20/21)

Black Women for Wellness Action Project (co-source)  
California Nurse Midwife Association (co-source)  
March of Dimes (co-source)  
NARAL Pro-Choice California (co-source)  
National Health Law Program (co-source)  
Western Center on Law and Poverty (co-source)  
Access Reproductive Justice  
ACLU California Action  
BreastfeedLA  
Business & Professional Women of Nevada County  
California Coalition of Welfare Rights Organizations  
California League of Conservation Voters  
California Pan-Ethnic Health Network  
California Women's Law Center  
Center on Reproductive Justice at Berkeley Law  
Children Now  
Children's Specialty Care Coalition  
Citizens for Choice  
Coalition of California Welfare Rights Organizations  
Consumer Watchdog  
Courage California  
Disability Rights Education and Defense Fund  
Empowering Pacific Islander Communities  
Essential Access Health  
Every Mother Counts  
Health Access California  
If/When/How: Lawyering for Reproductive Justice  
In Our Own Voice: National Black Women's Reproductive Justice Agenda  
LA Best Babies Network  
Los Angeles County Board of Supervisors  
Maternal and Child Health Access  
National Association of Social Workers, California Chapter  
National Center for Youth Law  
Plan C  
Planned Parenthood Affiliates of California  
Providence  
Public Law Center  
Religious Coalition for Reproductive Choice  
SBCC-Strength Based Community Change

**TEACH**

The Birth Equity Advocacy Project  
The Birthworkers of Color Collective  
The Children's Partnership  
The Coalition of 100 Black Women, Los Angeles Chapter  
The Praxis Project  
Time for Change Foundation  
Training in Early Abortion for Comprehensive Healthcare  
Three Individuals

**OPPOSITION:** (Verified 5/20/21)

None received

**ARGUMENTS IN SUPPORT:** A coalition letter from the sponsors of this bill states that although California has reduced the rates of maternal mortality over the past 30 years, mortality and morbidity for Black and Indigenous/Native American pregnant people, women, and infants remain considerably higher than the state's average. Research points to structural racism, as well as socioeconomic factors, contributing to the racial and geographic disparities seen in birthing outcomes of people of color. In addition, although we have not gotten updated data at the state level in several years, county data suggest that the racial disparities are widening, with deaths for Black birthing people ticking back up here in California. Between 2011 and 2013, the ratio of death for Black women was 26.4 per 100,000, almost 3.8 times higher than that for white women. In certain counties, the disparities are even greater. In Los Angeles County, the largest county in California, the rate of maternal death for Black women is over 4.5 times higher than the County overall rate for women. According to the Los Angeles County Office of Women's Health Indicators for Women in Los Angeles County 2013 report, the ratio of Black maternal mortality in Los Angeles was 58.6 per 100,000. In the 2018 version of the report, the number was 85.8 per 100,000. LA County's ratio for all women in the 2018 report was 17.9 per 100,000.

Meanwhile, California's infant mortality rate is 4.2 per 1000 live births, lower than the national average of 5.7. However, a closer look at the numbers demonstrates sharp racial disparities. Indigenous/Native American infants in California die at a rate of 11.7 per 1000 live births, followed by Black infants who die at a rate of 8.7 per 1000 live births. Higher numbers of Black and Asian and Pacific Islander pregnant and postpartum people report unfair treatment, harsh language, and rough handling during their labor/delivery hospital stay, as compared to white pregnant and postpartum people. Higher numbers of pregnant and postpartum people who

speaking an Asian Language or Spanish at home also report unfair treatment during their labor/delivery hospital stay, as compared to pregnant and postpartum people who speak primarily English at home. In addition, California is heading towards a maternal health crisis, with critical shortages in maternity providers predicted by 2025. Currently, California has nine counties that do not have a single OBGYN. California only has two nurse-midwifery programs in the entire state, and only one direct-entry midwifery program, approved by their respective state licensing boards. It is becoming increasingly difficult for these programs to expand the midwifery workforce in California to meet the demand in maternity care deserts and low access areas.

Prepared by: Melanie Moreno / HEALTH / (916) 651-4111  
5/22/21 9:52:38

\*\*\*\* **END** \*\*\*\*