

Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1882 (Ellis) – As Amended March 19, 2026

SUBJECT: Safe Delivery Fund Pilot Program.

SUMMARY: Establishes the Safe Delivery Fund Pilot Program (SDFP Program), until January 1, 2030, administered by the Department of Health Care Access and Information (HCAI) to provide funding to hospitals to offset uncompensated standby costs associated with maintaining specialty physician coverage, advanced practice provider coverage, and hospital staffing necessary to safely provide deliveries and related inpatient specialty services. Requires a hospital to meet specified requirements to qualify for the program, including, among other things, that the hospital can demonstrate that the hospital serves a geographically isolated population and that loss of obstetric services would significantly impact access to maternity care. Specifically, **this bill:**

- 1) Establishes the SDFP Program within HCAI to provide funding to hospitals that support standby capacity in a hospital for all of the following specialty services:
 - a) Inpatient general surgery;
 - b) A licensed labor and delivery inpatient unit with nursery beds; and,
 - c) Inpatient pediatrics capability.
- 2) Requires a hospital, to qualify for the program, to meet all of the following:
 - a) Maintain 24-hours-per-day, 7-days-per-week, 365-days-per-year clinical readiness to provide the services described 1) above, consistent with state and federal licensing and certification requirements;
 - b) Be a critical access hospital (CAH) that provides obstetric services;
 - c) Be located at least 75 miles from the nearest tertiary hospital;
 - d) Perform no more than 225 inpatient surgeries annually;
 - e) Maintain active licensure with the State Department of Public Health (DPH) and certification with the federal Centers for Medicare and Medicaid Services (CMS);
 - f) Maintain a valid Medi-Cal contract, including participation with the county-designated Medi-Cal managed care plans, as applicable; and,
 - g) Demonstrate that the hospital serves a geographically isolated population and that loss of obstetric services would significantly impact access to maternity care.
- 3) Requires a hospital to use the funds from the SDFP Program for salaries, benefits, insurance, contracted physician compensation, contracted advanced practice provider compensation, or other expenses attributable to maintaining standby clinical capacity.

- 4) Establishes the Safe Delivery Fund the primary purpose of which is to offset uncompensated standby costs associated with maintaining specialty physician coverage, advanced practice provider coverage, and hospital staffing necessary to safely provide deliveries and related inpatient specialty services.
- 5) Requires moneys in the fund to be available, upon appropriation by the Legislature, to the HCAI for the purposes of this bill.
- 6) Prohibits HCAI from awarding a hospital more than five million dollars (\$5,000,000) per year.
- 7) Requires HCAI, on an annual basis, to calculate standby costs, in consultation with providers, using the hospital's prior-year Medicare or Medi-Cal cost report, and to be composed of all of the following:
 - a) Medicare cost-based reimbursement;
 - b) Reimbursement from any other cost-based payer; and,
 - c) Federal disproportionate share hospital payments attributable to the covered specialty services, as specified by HCAI.
- 8) Authorizes HCAI to calculate standby costs per delivery using a time-study methodology and relative value units, or another allocation methodology established by HCAI.
- 9) Requires the SDFP Program to reimburse a hospital quarterly based on the number of deliveries performed per day, using the following schedule:
 - a) Twenty-five thousand dollars (\$25,000) for zero deliveries;
 - b) Eighteen thousand five hundred dollars (\$18,500) for one delivery;
 - c) Twelve thousand dollars (\$12,000) for two deliveries;
 - d) Five thousand five hundred dollars (\$5,500) for three deliveries;
 - e) Zero dollars (\$0) for four or more deliveries.
- 10) Authorizes HCAI to conduct audits of a participating hospital's cost reports.
- 11) Requires, by April 1, 2027, and quarterly thereafter, a participating hospital to submit to HCAI all of the following data:
 - a) Number of deliveries performed per day;
 - b) Maintenance of specialty staffing and service availability;
 - c) Quality metrics, including at minimum three maternal and infant quality indicators to be specified by HCAI; and,
 - d) Verification of costs using annual Medicare or Medi-Cal cost reports.

- 12) Authorizes HCAI to conduct annual audits or program reviews to ensure both of the following:
 - a) Funds are used to maintain standby specialty service capacity; and,
 - b) Hospitals continue to meet eligibility criteria and quality requirements.
- 13) Requires a hospital to meet all of the program requirements for continued participation in the program.
- 14) States that the provisions of this bill will remain in effect only until January 1, 2030, and as of that date are repealed.

EXISTING LAW:

- 1) Establishes HCAI in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [Health and Safety Code (HSC) § 127000, *et seq.*]
- 2) Establishes the California Reproductive Health Service Corps for the purposes of recruiting, training, and retaining a diverse workforce of reproductive health care professionals who will be part of reproductive health care teams to work in underserved areas. [HSC § 128560]
- 3) Licenses and regulates health facilities by DPH, including general acute care hospitals (GACHs). Permits GACHs, in addition to the basic services required to be offered under that license, to seek approval from DPH to offer supplemental services. Defines a GACH to mean a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Specifies that a GACH, as defined, includes a “rural GACH.” Prohibits a rural GACH from being required by DPH to provide surgery and anesthesia services. [HSC § 1250 and § 1255]
- 4) Makes hospitals designated as a CAH by the Department of Health Care Services (DHCS), and certified as such by the federal Department of Health and Human Services, eligible for supplemental payments for Medi-Cal covered outpatient services. [Welfare and Institutions Code (WIC) § 14105.17]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, for the residents of Ridgecrest and the workforce at China Lake Naval Air Weapons Station, Ridgecrest Regional Hospital is a lifeline. Without local access to labor and delivery, expectant mothers face dangerous multi-hour drives for basic prenatal services. This creates an untenable burden for those stationed here for our national security. The author states that this bill addresses this crisis by establishing the SDFP Program, which will provide the targeted financial support necessary to maintain 24/7 standby clinical capacity. The author concludes that this bill is a critical

investment in the operational readiness of our military and the long-term health of a geographically isolated community.

- 2) **BACKGROUND.** In the past decade, more than 50 labor and delivery wards have closed in California hospitals. As a result, large areas of California are without access to birthing facilities or maternity care providers. The absence of access to maternity care has disproportionately impacted California's low-income, Black, Latinx, and Indigenous populations, and those living in rural communities. When maternity wards close, particularly in rural counties, birthing people receive less prenatal care and rates of preterm birth increase. Currently, twelve California counties, most of them rural, do not have any hospitals delivering babies.

- a) **Maternity care in California.** According to the California Health Care Foundation's 2023 Health Care report, "Maternity Care in California," access to quality maternal care is essential for positive birth outcomes. In California, 46,000 women age 15 to 44 live in counties with no hospitals with obstetrics care or birth centers, and an additional 76,000 live in counties with only one hospital with obstetrics care or a birth center. Fifty-one thousand women age 18 to 44 live in counties with fewer than 29 obstetricians or certified nurse midwives per 10,000 births. In 2021, births to Latina/x mothers and birthing people made up nearly half of all births in the state, at just under 200,000 births. About 3 in 10 births in California were to mothers or birthing people born outside the United States.

California's pregnancy-related mortality rate has fluctuated since 2009. It increased by 45% from 2019 to 2020, possibly due to COVID-19. About one in four deaths occurred on the day of delivery between 2018 and 2020. A recent Centers for Disease Control and Prevention analysis found that more than four in five pregnancy-related deaths were preventable. Between 2009 and 2020, the pregnancy-related mortality rate for Black mothers and birthing people was three to four times higher than the rate for mothers and birthing people of other races/ethnicities. This variation cannot be explained by factors such as age, income, education, and health insurance coverage. Research shows that implicit bias and racism are key causes of disparate outcomes for Black mothers and birthing people.

- b) **Maternity unit closures.** On November 15, 2023, *CalMatters* published an investigative story focusing on the increase in maternity unit closures in California, titled "As Hospitals Close Labor Wards, Large Stretches of California Are Without Maternity Care." According to this report, from 2012 to 2019, at least 19 hospitals stopped offering labor and delivery services (six of those were because the hospitals closed completely).

The *CalMatters* report stated that hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, and declining birth rates. In the past 30 years, the number of births have dropped by half in California, and the birth rate is at its lowest level on record. *CalMatters* noted that the trend is not unique to California, with labor and delivery units closing across the country. Many closures result from hospital systems consolidating maternity care into one location, which hospitals argue can help maintain staff training and provide a higher level of care. According to *CalMatters*, labor and delivery units are often the second-most expensive department for hospitals to run,

second only to emergency rooms, and quoted a health researcher as stating that obstetrics units are often unprofitable for hospitals to operate.

- c) **CAHs.** CAHs are licensed general acute care hospitals that are federally designated and certified to receive cost-based reimbursement from Medicare, which is intended to reduce hospital closures in rural areas. To be certified as a CAH, a hospital can have no more than 25 beds and must be located in a rural area and: i) more than 35 miles from another hospital; or, ii) 15 miles from another hospital in mountainous terrain or an area with only secondary roads. Other requirements include operating an emergency department, and having an annual average length of stay of 96 hours or less per patient.
- d) **Medi-Cal Hospital Reimbursement.** Medi-Cal hospital reimbursement is complicated and multi-layered. First, hospitals receive different types of Medi-Cal payment depending on whether the patient they are treating is enrolled in a managed care plan or in Fee-for-Service (FFS) Medi-Cal. Second, hospitals also deliver care in different settings— inpatient, outpatient, and nursing facilities— and different reimbursement mechanisms apply to these three types of care within each of the two delivery systems (FFS and managed care). Third, a hospital’s status as designated public hospital, district hospital, or private hospital determines how a hospital is paid and eligibility for supplemental payments. Finally, CAHs are treated separately for purposes of certain types of payments.

Broadly speaking, hospital payments are comprised of both “base rate”—e.g., the type of payment that may correspond to an itemized bill for an episode of service—as well as supplemental payments. The term “supplemental payments” has become somewhat of a misnomer, as these payments have grown in recent years to comprise a large proportion of many hospitals’ total Medi-Cal revenue.

Designated public hospitals, which include county-administered and University of California hospitals, have a reimbursement methodology that is highly specific to this class of hospital. The majority of hospitals, i.e., private hospitals or other public (district) hospitals, are paid through similar mechanisms with respect to the “base rate,” but differ in their eligibility for and participation in various Medi-Cal supplemental payment programs. Medi-Cal reimbursement mechanisms that currently apply for inpatient care CAHs are described below.

- e) **Reimbursement for CAHs in Medi-Cal.** In FFS Medi-Cal, inpatient services are reimbursed via a mechanism called diagnosis-related group (DRG). Within the DRG system, CAHs are eligible for a CAH-specific rate, a prospective rate that is projected to cover 95% of their costs, with costs aggregated across the class of CAHs as a whole and not on a per-hospital basis.

With respect to base rates for Medi-Cal inpatient services in Medi-Cal managed care, rates are negotiated between plans and CAHs; however, the Medi-Cal FFS rate often serves as a benchmark in these negotiations.

With respect to supplemental payments, a CAH is eligible for payments based on whether it is a district hospital or a private hospital. CAHs that are district hospitals participate in two inpatient supplemental payment programs, the District Hospital Directed Payment Program and the District Hospital Quality Improvement Program. CAHs that are private

hospitals participate in the hospital quality assurance fee (HQAF) supplemental payment program.

This bill, in addition to the supplemental payments above, requires HCAI to provide funding to hospitals to offset uncompensated standby costs associated with maintaining specialty physician coverage, advanced practice provider coverage, and hospital staffing necessary to safely provide deliveries and related inpatient specialty services.

- f) **Ridgecrest Regional Hospital.** According to a 2025 California Hospital Association report (CHA report), “Maternity care in California: an environmental scan,” after more than 65 years delivering babies, the Central Valley’s Ridgecrest Regional Hospital shuttered labor and delivery services in the spring of 2024, due to a shortage of obstetric clinicians and an annual loss of \$5 million to \$6 million attributed to the high costs associated with running a labor and delivery unit and low reimbursement rates for services. Expectant moms in the community, built around the Naval Air Weapons Station China Lake, had to travel as many as two hours to deliver their babies. Emergency funding from the U.S. military has enabled services to resume for now.
 - g) **Cost of providing maternity services.** The CHA report also notes that the cost of maintaining hospital labor and delivery services in California has been influenced by several factors:
 - i) Financial Performance: California hospitals have seen a significant increase in total net patient revenue and operating expenses, indicating rising costs associated with delivering care.
 - ii) Labor and Delivery Unit Closures: Over 50 labor and delivery units have closed in recent years due to cost pressures and staff shortages, reflecting the financial challenges faced by hospitals.
 - iii) Cost of Delivering Births: The cost of giving birth in California includes various services such as pharmacy, nursery, labor and delivery room, medical and surgical supplies, and anesthesia, with median charges for C-sections and vaginal deliveries being around \$15,555 and \$12,968, respectively.
- 3) **SUPPORT.** Ridgecrest Regional Hospital supports this bill and states that as a provider of labor and delivery services, inpatient pediatric care, and general surgery, Ridgecrest plays a vital role in ensuring that patients in remote communities can access timely and life-saving care close to home. Notably, Ridgecrest has previously faced disruptions to its labor and delivery services due to financial pressures, underscoring the need for targeted support like that proposed in this bill. Hospitals like Ridgecrest must maintain 24/7 clinical readiness, including specialized staffing and coverage, regardless of patient volume. However, low delivery volumes in rural areas make it difficult to sustain these services under current reimbursement structures, as the high fixed “standby” costs are not adequately offset. Without targeted support, hospitals may be forced to scale back or eliminate maternity services altogether, further exacerbating access challenges for vulnerable populations.

Ridgecrest notes that this bill takes a targeted approach by establishing a pilot program to offset these uncompensated standby costs. By providing funding tied to delivery volume while recognizing the need for continuous readiness, the bill helps stabilize essential services

in communities where alternatives may be many miles away. Importantly, the program includes oversight and reporting requirements to ensure accountability and allow the state to evaluate its effectiveness over time. Ridgecrest concludes that ensuring access to safe, local maternity care is critical for the health and well-being of families in rural and isolated regions.

4) RELATED LEGISLATION. AB 1923 (Soria) would make a hospital, regardless of ownership type or system affiliation eligible for state assistance under the Distressed Hospital Loan Program (DHLP). Would require the evaluation for loan forgiveness in the DHLP to incorporate projections of future financial performance, and, in place of the current criteria, would require HCAI to provide loan forgiveness to any participant in DHLP who received a loan award before the effective date of this bill, if HCAI and the California Health Facilities Financing Authority (CHFFA) determine the participant has demonstrated a good faith effort to comply with program requirements through January 1, 2026, and the financial projections demonstrate that the participant will become financially distressed as a result of loan repayments or other outside factors, including, but not limited to, the impacts of the federal One Big Beautiful Bill Act. Would appropriate \$300,000,000 from the General Fund to the DHLP to provide additional rounds of funding to hospitals in financial distress. AB 1923 is pending in the Assembly Health Committee.

5) PREVIOUS LEGISLATION.

- a) SB 32 (Weber Pierson) of 2025 would have required the Department of Managed Health Care, the Department of Insurance, and DHCS to consult with stakeholders to develop and adopt standards for the geographic accessibility of perinatal units to ensure timely access for enrollees and insureds. SB 32 was held on the Assembly Appropriations Committee suspense file.
- b) SB 669 (McGuire) Chapter 603, Statutes of 2025 requires DPH to establish a five-year pilot project to allow critical access and individual and small system rural hospitals to establish standby perinatal medical services. Requires a participating hospital to be greater than 60 minutes from the nearest hospital providing full maternity services and not have closed a full maternity or labor and delivery department on or after January 1, 2025.
- c) AB 1386 (Bains) of 2025 would have included perinatal services as a required basic hospital service, beginning on an unspecified date. Requires DPH to establish a process to approve or deny a perinatal service compliance plan to meet the requirement to provide perinatal services, and requires hospitals that do not provide perinatal services to submit a perinatal service compliance plan to DPH. AB 1386 was held on the Assembly Appropriations Committee suspense file.
- d) AB 1918 (Petrie-Norris) Chapter 561, Statutes of 2022 establishes the California Reproductive Health Service Corps within HCAI to recruit, train, and retain a diverse workforce of reproductive health care professionals to work in underserved areas.

REGISTERED SUPPORT / OPPOSITION:

Support

Ridgecrest Regional Hospital

Opposition

None on file

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