ASSEMBLY THIRD READING
AB 1882 (Ellis)
As Amended March 19, 2026
Majority vote

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.

COMMENTS

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 disproportionally 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.

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 three in 10 births in California were to mothers or birthing people born outside the United States.

Critical Access Hospitals (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.

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.

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.

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.

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.

Arguments in 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.

Arguments in Opposition
None on file.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, General Fund cost pressures in the millions of dollars per year. The author has requested an allocation of up to $5 million annually to fund this bill as a pilot program. Costs to HCAI to administer the program could be in the hundreds of thousands to low millions, depending on how many hospitals participate.

VOTES

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Aguiar-Curry, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

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