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## SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

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**BILL NO:** AB 1882  
**AUTHOR:** Ellis  
**VERSION:** March 19, 2026  
**HEARING DATE:** July 1, 2026  
**CONSULTANT:** Vincent D. Marchand

**SUBJECT:** Safe Delivery Fund Pilot Program

**SUMMARY:** Establishes the Safe Delivery Fund Pilot Program to provide funding to critical access hospitals that meet specified requirements in order to support the cost of maintaining standby capacity for labor and delivery units that have a lower volume of baby deliveries.

**Existing law:**

- 1) Licenses and regulates health facilities by the California Department of Public Health (CDPH), including general acute care hospitals. Permits general acute care hospitals, in addition to the basic services required to be offered under that license, to seek approval from CDPH to offer supplemental services. Defines a “supplemental service,” in regulations, as an organized inpatient or outpatient service which is not required to be provided by law or regulation. [HSC §1250 and 22 CCR §70067]
- 2) Defines “perinatal unit,” in regulation, as a maternity and newborn supplemental service of a hospital for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space, equipment and supplies. [22 CCR §70545]
- 3) Licenses and regulates clinics by CDPH, including primary care clinics and specialty clinics. Includes alternative birth centers as a category of specialty clinic, defined as a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility. [HSC §1200 et seq., and §1204(b)]
- 4) Requires a hospital, not less than 120 days prior to eliminating a supplemental service of either an inpatient psychiatric unit or a perinatal unit, to provide public notice of the proposed elimination of the supplemental service, including a notice posted at the entrance to all affected facilities, a notice to all contracted Medi-Cal managed care plans, and a notice to CDPH and the board of supervisors of the county in which the hospital is located. Requires the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the supplemental service. [HSC §1255.25(a)(3)]

**This bill:**

- 1) Establishes the Safe Delivery Fund Pilot Program (Pilot Program) within the Department of Health Care Access and Information (HCAI) to provide funding to hospitals that support standby capacity for 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 meet the following requirements in order to qualify for the Pilot Program:

- a) Maintain 24-hours-per-day, 7-days-per-week, 365-days-per-year clinical readiness to provide the services 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 CDPH and certification from the Centers for Medicare and Medicaid Services;
  - f) Maintain a valid Medi-Cal contract, including participation with 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 Pilot Program funds 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 (Fund) 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 HCAI for the purposes of this bill.
  - 6) Prohibits HCAI from awarding a hospital more than \$5 million 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:
    - 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) Requires HCAI to calculate standby costs per delivery using a time-study methodology and relative value units, or another allocation methodology it establishes.
  - 9) Requires the Pilot Program to reimburse a hospital quarterly based on the number of deliveries performed per day, using the following schedule:
    - a) \$25,000 for zero deliveries;
    - b) \$18,500 for one delivery;
    - c) \$12,000 for two deliveries;
    - d) \$5,500 for three deliveries; and,
    - e) \$0 for four or more deliveries.
  - 10) Requires a participating hospital, by April 1, 2027 and quarterly thereafter, to submit the following data to HCAI:
    - 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.

11) Permits HCAI to conduct audits of a participating hospital’s cost reports and to conduct annual audits or program reviews to ensure that funds are used to maintain standby specialty service capacity, and that hospitals continue to meet eligibility criteria and quality requirements.

12) Sunsets the provisions of this bill on January 1, 2030.

**FISCAL EFFECT:** 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.

**PRIOR VOTES:**

Assembly Floor:	77 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0

**COMMENTS:**

- 1) *Author’s statement.* 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. This bill addresses this crisis by establishing the Safe Delivery Fund Pilot Program, which will provide the targeted financial support necessary to maintain 24/7 standby clinical capacity. 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 provided by author and budget request.* According to the author, hospitals serving low-volume, geographically isolated populations especially face a structural financial gap, as existing reimbursement systems are largely volume-based and do not adequately account for these continuous “standby” costs. As a result, some hospitals are at risk of reducing or discontinuing maternity and related services, which can significantly impact access to care in communities where alternative facilities may be far away. The author believes that by tying funding to delivery volume, while recognizing fixed operational needs, the Pilot Program aims to stabilize access to care in underserved regions. The author did submit a funding request for the 2026-2027 state budget to support the Pilot Program proposed by this bill. Specifically, the author requested an appropriation of up to \$5 million annually per eligible hospital, through January 1, 2030, consistent with the funding structured in this bill.
- 3) *Background on perinatal units in hospitals.* With some exceptions, general acute care hospitals are required to provide eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary. Beyond these basic services, hospitals can be authorized to offer supplemental services, including outpatient services such as emergency

services, or inpatient services such as intensive care, cardiovascular surgery, psychiatric units, and perinatal units, among other supplemental services.

Perinatal units are defined in regulations as a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum, and neonatal periods with appropriate staff, space, equipment and supplies. The regulations pertaining to the required staff for perinatal units specify that a physician certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics is required to have overall responsibility of the unit. If a physician with those qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics is permitted to administer the service, while a physician with the necessary qualifications provides consultation at a frequency that will ensure high quality service. Regulations require the physician to be responsible for providing continuous obstetric, pediatric, anesthesia, laboratory, and radiologic coverage, among other requirements. They also require one registered nurse on duty on each shift assigned to the labor and delivery suite, with sufficient additional trained personnel to assist the family, monitor and evaluate labor and assist with the delivery. One registered nurse is required to be on duty for each shift assigned to the antepartum and postpartum areas, and a registered nurse who has had training and experience in neonatal nursing is required to be responsible for the nursing care in the nursery.

- 4) *CAHs*. CAHs are licensed general acute care hospitals that are 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: (1) more than 35 miles from another hospital; or, (2) 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. There are 34 CAHs in California.
- 5) *Sharp increase in 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). In an acceleration, 16 more closed maternity services from 2020 to 2022. By the time of publication, 11 more had announced maternity closures in 2023, including one hospital that closed completely (Madera Community Hospital). *CalMatters* reported that after El Centro Regional Medical Center closed its maternity service in January of 2023, Imperial County was left with only one hospital doing births for the approximately 2,500 babies born every year in Imperial County. In total, according to *CalMatters* analysis, at least 46 California hospitals have shut down or suspended labor and delivery since 2012, and 27 of those have taken place in the last three years. Twelve rural counties do not have any hospitals delivering babies, and Latino and low-income communities have been hit hardest by losses. *CalMatters* noted that the closures come as the country and state contend with a maternal mortality crisis, with pregnancy-related deaths reaching a ten-year high in 2020 in California.

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.

On February 8, 2024, Adventist Health Simi Valley announced it was closing its labor and delivery department and neonatal intensive care unit effective May 8, 2024. Adventist stated that births had declined by 25% at the hospital and it could no longer sustain the service. Adventist noted that Ventura County births dropped from 19 per 1,000 in 1990 to 10.5 per 1,000 in 2021. Earlier this year, Alameda Health System, which recently acquired St. Rose Hospital in Hayward, announced it was “temporarily suspending” its birthing center at St. Rose on February 18, for 12 to 18 months as they work to evaluate and improve birthing services.

- 6) *Distressed Hospital Loan Program (DHLP)*. The DHLP was established through AB 112 (Committee on Budget, Chapter 6, Statutes of 2023), following the closure of Madera Community Hospital, in an effort to prevent further hospital closures and to help facilitate the reopening of Madera. AB 112 initially funded the DHLP at \$150 million, but an additional \$150 million was later appropriated to make it a \$300 million loan program. After development of an application process and reviewing applications from 30 hospitals, HCAI awarded loans to 17 hospitals. Under the terms of the DHLP, the loans are interest free, and hospitals are to begin making monthly payments 18 months following disbursement of the loan. The loans are required to be repaid within 72 months of the date of the loan. The DHLP also required HCAI to develop, in consultation with the California Health Facilities Financing Authority (CHFFA), and upon the approval of the Department of Finance, a process for hospitals who received DHLP loans to request forgiveness or loan modifications. On February 3, 2025, HCAI and CHFFA began accepting applications for loan modifications for a 12-month extension of the loan payment deferral period.
- 7) *Informational letter from Naval Air Warfare Center*. The Commanding Officer of the Naval Air Warfare Center Weapons Division submitted a letter providing information regarding the direct impact of local health care availability on national security operations at Naval Air Weapons Station (NAWS) China Lake. The purpose of the letter was to provide factual context between the availability of specific local healthcare services and the execution of the national security mission at the base in order to inform legislative understanding of their unique operational environment. The letter states that NAWS China Lake is a critical component of the nation’s defense infrastructure, responsible for the research, development, test, acquisition, and evaluation of the U.S. Navy’s most advanced weapons systems, and this mission is dependent on a highly specialized workforce of 600 Active Duty Sailors, 5,000 Department of Defense civilians, and 800 civilian contractors. The mission has a single point of failure for health care. A 2024 assessment identified NAWS China Lake as the only installation in the Department of War with a single supporting hospital, Ridgecrest Regional Hospital, and no alternative within a 60-minute drive. The financial fragility of this sole provider stems from a confluence of systemic challenges, and the immense fixed costs required to maintain 24/7 “standby capacity” for critical but lower-volume services cannot be sustained under standard fee-for-service models in geographically isolated areas. The letter states that preservation of this standby clinical capacity for essential services, specifically inpatient general surgery, labor and delivery, and inpatient pediatrics, is foundational to

retaining their critical workforce and avoiding the severe consequences experienced during the recent temporary loss of these services. According to the letter, a September 2024 survey revealed that the health care crisis was a primary driver of attrition risk, with 22% of the workforce actively making plans to leave. Federal intervention was required to prevent the projected departure of more than 350 specialized personnel. The nine-month suspension of labor and delivery services forced hundreds of expectant mothers to travel 90 to 150 miles for care through the Mojave Desert with little cellular connectivity. More alarmingly, 15 births occurred in the emergency department without prenatal care, a complete breakdown in the standard of care. The letter states that data confirms that without mechanisms to support the unique standby costs of rural healthcare, instability in these core services acts as an existential threat to their workforce.

- 8) *Related legislation.* AB 1923 (Soria) revises the DHLP by expanding eligibility to any hospital, regardless of ownership type or system affiliation, and to require loan forgiveness to prior recipients of loans under this program if financial projections demonstrate that the participant will become financially distressed as a result of loan repayments under the program or other outside factors such as the impacts of HR 1. *AB 1923 is set for hearing on July 1<sup>st</sup> in this Committee.*
- 9) *Prior legislation.* AB 108 (Gabriel, Chapter 8, Statutes of 2026) was a Budget Bill Junior which increases a General Fund appropriation in the Budget Act of 2025, in this case to provide \$25 million to support grants to hospitals in immediate and significant financial distress, defined as those with less than ten days cash on hand.

SB 32 (Weber Pierson of 2025) would have required the Department of Managed Health Care, the Department of Insurance, and the Department of Health Care Services 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.*

AB 55 (Bonta, Chapter 595, Statutes of 2025) removes the requirement that an alternative birth center be a comprehensive perinatal services provider as a condition of licensure, and a condition for Medi-Cal reimbursement. AB 55 removes the requirement that an alternative birth center be 30 minutes from a hospital.

SB 1300 (Cortese, Chapter 894, Statutes of 2024) extends the public notice requirement when a health facility eliminates a supplemental service, currently 90 days prior to elimination of the service, to instead be 120 days when it involves the closure of either inpatient psychiatric services or perinatal services, expands the notice of closure to include data on the patients served and a justification for the decision to eliminate services, and requires the hospital to hold a public hearing within 60 days of providing the notice.

AB 1895 (Weber of 2024) would have required a hospital that operates a perinatal unit, and expects challenges in the next six months that may result in a reduction or loss of perinatal services, to make a report to HCAI, and for HCAI to forward this report to relevant state departments and to the Chairs of the Senate and Assembly Health Committees, but otherwise required this report to be kept confidential. AB 1896 would have required HCAI to do a community impact assessment of a potential closure within 90 days of receiving a report from a hospital, and to share this impact assessment with state agencies and the two policy committee chairs, but otherwise required this impact assessment to be kept confidential

unless the hospital announces a closure of the perinatal services. *AB 1895 was vetoed by the Governor, who stated in part: "...current law already requires hospitals to provide public notice in advance of a supplemental service elimination, and much of the information in the proposed community impact report is duplicative. Further, this bill creates costly administrative burdens for the state that are unlikely to change hospitals' business decisions."*

SB 45 (Roth of 2023) would have established the California Acute Care Psychiatric Hospital Loan Fund to provide zero-interest loans to qualifying county applicants for the purpose of constructing or renovating acute care psychiatric hospitals or psychiatric health facilities, or renovating or expanding general acute care hospitals in order to add or expand an inpatient psychiatric unit. *SB 45 was held on the Assembly Appropriations Committee suspense file.*

AB 112 (Committee on Budget, Chapter 6, Statutes of 2023) establishes the DHLP to provide interest free cash-flow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals. Requires HCAI to administer the DHLP and to enter into an interagency agreement with CHFFA to implement the DHLP.

10) *Support.* This bill is sponsored by Ridgecrest Regional Hospital, which is a CAH serving a geographically isolated region where access to essential health service is already limited. Ridgecrest states that as a provider of labor and delivery, inpatient pediatric care, and general surgery, the hospital plays a vital role in ensuring that patients in remote communities can access timely and life-saving care close to home. Ridgecrest notes that it has previously faced disruptions to its labor and delivery services due to financial pressures, underscoring the need for targeted support as proposed by this bill. Without targeted support, hospitals may be forced to scale back or eliminate maternity services altogether, further exacerbating access challenges for vulnerable populations. By providing funding tied to delivery volume while recognizing the need for continuous readiness, this bill helps stabilize essential services in communities where alternatives may be many miles away.

**SUPPORT AND OPPOSITION:**

**Support:** Ridgecrest Regional Hospital (sponsor)  
 Department of the Navy, Military Services in California  
 Indian Wells Valley Economic Development Corporation  
 Military Services in California  
 Ridgecrest Area Association of Realtors  
 Ridgecrest Chamber of Commerce  
 One individual

**Oppose:** None received

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