Date of Hearing: July 16, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 669 (McGuire) – As Amended July 3, 2025

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the California Department of Public Health (CDPH) establish a five-year pilot project to allow eligible rural hospitals to provide "standby perinatal medical services," including emergency obstetric care through physician, midwifery, and nursing services available within 30 minutes. The bill requires CDPH, in consultation with stakeholders, to develop a monitoring plan and reporting template to collect and evaluate data, and to report to the Legislature within two years of the end of the pilot.

Specifically, this bill:

1) Defines "critical access hospital" to mean a hospital designated by CDPH and certified as a critical access hospital by the Secretary of the U.S. Department of Health and Human Services under the federal Medicare Rural Hospital Flexibility Program.

2) Defines "rural hospital" by reference to mean a "rural general acute care hospital" or a hospital located in a rural (population density less than 250 persons per square mile) or frontier (less than 11 persons per square mile) medical service study area, as defined by the California Healthcare Workforce Policy Commission.

3) Defines "standby perinatal medical services" to mean emergency obstetric medical care provided by physician, midwifery, and nursing services within 30 minutes in a specifically designated area of the hospital that is equipped and maintained at all times to receive patients with urgent obstetric problems.

4) Requires CDPH establish a five-year pilot project to allow critical access hospital and individual and small system rural hospitals to establish standby perinatal medical services, and to do the following:

    a) Determine eligibility for hospitals to participate in the pilot project.

    b) Develop a monitoring plan and reporting template to collect and evaluate data on safety, outcomes, utilization, and populations served.

    c) Use collected data to prepare, within two years of completion of the pilot project, an evaluation to submit to the Legislature and make publicly available.

    d) Requires CDPH consult with specified stakeholders representing hospitals, consumers, specified physician and nurse-midwife groups, health plans, labor organizations, and

other specified health care professionals who provide pediatric and pregnancy-related services, to meet the requirements of this bill.

5) Requires, to qualify for the pilot program, a critical access or individual and small system rural hospital:

   a) Be more than 60 minutes from the nearest hospital providing full maternity services.

   b) Not have closed a full maternity or labor and delivery department on or after January 1, 2025.

   c) Agree to provide basic level I maternal and neonatal services pursuant to the American College of Obstetricians and Gynecologists (ACOG) Levels of Maternal Care.

6) Authorizes a hospital participating in the pilot program and meeting the requirements in this bill to serve as the hospital with the capacity for the management of obstetrical and neonatal emergencies for an alternative birth center (ABC), as defined.

7) Requires a hospital selected for a pilot program pursuant to this bill comply with the following:

   a) Have written policies and procedures consistent with basic level I perinatal care, as defined.

   b) The physician responsible for the standby perinatal medical services, in consultation with other appropriate health professionals and administration, must develop and maintain the written policies and procedures regarding various specified aspects of providing perinatal care, such as relationships to other services in the hospital, admission policies, consultations, telemedicine services for consultation, transfer of patients to a higher level or intensive care, among many others.

   c) The policies required in b, above, must be approved by the medical staff and the governing body.

8) Requires a physician who is certified, or eligible for certification, by the American Board of Obstetrics and Gynecology, the American Board of Pediatrics, or the American Board of Family Medicine, and who is a member of the medical staff of the facility, have overall responsibility for a pilot program. Specifies the responsibilities of the physician must include:

   a) Implementation of established policies and procedures.

   b) Development of a system for assuring physician coverage on call 24 hours a day to the standby perinatal medical services.

   c) Assurance that physician coverage is available within 30 minutes.

   d) Development of a roster of specialty physicians available for consultation at all times.

   e) Maintaining work relationships with intensive care newborn nursery.

f) Development of specified order sets for pregnant patients presenting to the emergency department and for the perinatal standby unit.

9) Requires a hospital selected for the pilot program maintain specified equipment and supplies necessary for mothers and infants needing emergency or immediate life support to sustain life up to 12 hours or to prevent major disability.

10) Requires a hospital selected for the pilot program maintain specified capabilities, including necessary equipment, to provide low-risk maternal care and readiness at all times to initiate emergency procedures to meet unexpected needs of women and newborns.

11) Requires a hospital selected for a pilot project pursuant to this bill to maintain specified resuscitation equipment.

12) Requires a hospital selected for the pilot program maintain specified capabilities and equipment necessary for stabilization and to facilitate transport to a higher-level hospital when necessary.

13) Requires a hospital selected for the pilot program, in collaboration with higher-level facility partners, maintain the ability to initiate and sustain education and develop a quality improvement program to maximize patient safety.

14) Makes findings and declarations related to access to hospital maternity services in rural areas.

FISCAL EFFECT:

CDPH estimates total costs of approximately $480,000 in fiscal year (FY) 2026-27, $1.45 million in FY 2027-28, and $518,000 per year in FY 2028-29 through FY 2030-31 (Licensing and Certification Fund).

These costs include $480,000 in fiscal year (FY) 2026-27 and $252,000 per year in FY 2027-28 through FY 2030-31 for staff and administration to determine eligibility and evidence of compliance with service requirements, develop a monitoring plan and reporting template, monitor and oversee the pilot, compile and evaluate collected data, and report to the Legislature.

Other costs are due to information technology (IT) requirements, as CDPH reports this bill will invoke the Project Approval Lifecycle (PAL) planning process. Although this project does not appear to be highly data-intensive, CDPH estimates the total cost to design, develop, and implement, including ongoing maintenance and operation, is approximately $1.2 million in FY 2027-28 and $266,000 per year in FY 2028-29 through FY 2030-31.

CDPH bases its fiscal estimate on an assumption that 17 hospitals would participate in the pilot program. If fewer hospitals participate, the costs to CDPH would be lower.

COMMENTS:

1) **Purpose.** This bill is sponsored by Partnership Health Plan, Association of California Health Care Districts, and Plumas District Hospital. According to the author:

> One of the most significant health care access problems in my district is lack of access to labor and delivery care. Due to falling birth rates,

staffing and fiscal challenges, hospitals are closing maternal care units. In response, I am proposing an innovative model to increase access in these maternal desserts. This bill would allow a birthing center to be located in or near a rural hospital which has specially trained staff on call if needed. The hospital would be required to meet alternative standards relating to on-call staffing, training, equipment and services in order to protect patient safety. According to data collected by CalMatters, [since 2012, 56 hospitals or 16% of all general acute care hospitals in California have stopped delivering babies]. At the same time, there is an unmet demand for alternative birthing centers for those with low risk pregnancies. Studies are showing that expanding access to the midwifery model at birthing centers as well as the use of doulas not only increases access but also improves outcomes for all women. Birthing centers also provide comprehensive prenatal care eliminating the need to travel long distances over country roads for prenatal and postpartum care. Currently, deliveries are occurring in transit to a distant hospital, with a scheduled but possibly unnecessary caesarian procedure, in emergency department, in small rural hospitals and at home. This model will provide a safer local alternative.

2) **Background.** According to reporting by CalMatters in November 2023, from 2012 to 2019, at least 19 hospitals stopped offering labor and delivery services (six of those were hospitals that closed completely). From 2020 to 2022, 16 more hospitals closed maternity services, and 11 more announced maternity closures in 2023, including one hospital that closed completely. 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 to deliver the approximately 2,500 babies born every year in Imperial County. Twelve rural counties do not have any hospitals delivering babies, and Latino and low-income communities are most affected by closures.

Plumas District Hospital (Plumas). Plumas, in Quincy, is a critical access hospital licensed for 16 beds, with an average daily census of 5.5. Plumas, the last frontier hospital in California to offer maternity services, closed its perinatal unit in 2022 due to the decline in hospital births and difficulty of maintaining necessary staffing for a perinatal unit. Plumas proposes a model in which an ABC would use the midwifery model to provide low-risk birthing. Rural health clinics would provide perinatal, newborn, and women's care, and would triage obstetric risk and coordinate care. Plumas would provide obstetric and newborn emergency stabilization for transfer to a higher level of care, but would also have capability to perform emergency deliveries and cesarean sections when necessary. However existing California law requires an ABC to be within 30 minutes of a facility with the capacity for management of obstetrical and neonatal emergencies. Because Plumas closed its perinatal unit, it cannot serve this role under existing law. The next closest hospital is 87 miles away.

As California regulations permit a hospital to provide "Standby Emergency Medical Service, Physician on Call," the Plumas Model proposes to create a standby perinatal unit that could serve as the facility "with the capacity for management of obstetric and neonatal emergencies." A standby unit, with the requirement that staffing be available on an on-call basis, would enable a hospital like Plumas to provide this service, compared with the financial and staffing challenges of maintaining a full perinatal unit with round-the-clock

staffing of obstetric providers and nurse specialists.

3) **Related Legislation.**
AB 55 (Bonta) removes the requirement that an ABC be a comprehensive perinatal services provider as a condition of licensure and a condition for Medi-Cal reimbursement. AB 55 also removes the requirement that an ABC be 30 minutes from a hospital. AB 55 is on suspense in the Senate Appropriations Committee.

AB 1386 (Bains) includes perinatal services as a required basic hospital service, beginning on an unspecified date, requires a hospital that does not provide perinatal services to submit a perinatal service compliance plan to CDPH, and requires CDPH to establish a process to approve or deny a perinatal service compliance plan. AB 1386 was held in this committee.

SB 32 (Weber Pierson) requires 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 is pending in this committee.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081