SENATE THIRD READING
SB 669 (McGuire)
As Amended September 5, 2025
Majority vote

SUMMARY

Requires the State Department of Public Health (DPH), by July 1, 2026, in consultation with stakeholders, to establish a ten-year pilot project to allow up to five critical access hospitals to establish standby perinatal medical services. Requires the first three hospitals selected to be nonprofit hospitals located in Humboldt and Plumas County, if they qualify. Requires the hospitals, in order to qualify for the pilot project, to meet specific requirements regarding the equipment and services that must be available, define the responsibilities of the medical staff, and develop a quality improvement program, among other things. Requires DPH to develop a monitoring plan and reporting template to collect and evaluate data on safety, outcomes, utilization, and populations served, and submit an evaluation to the Legislature. Requires a physician to have overall responsibility for the pilot program.

Major Provisions

COMMENTS

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.

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. 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. Research shows that implicit bias and racism are key causes of disparate outcomes for Black mothers and birthing people.

Recent increase in maternity unit closures. On November 15, 2023, *CalMatters* published an investigative report 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. 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.

Perinatal units. 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 perinatal units establish a number of staffing requirements, including the following:

1) A physician certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics must 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 assure high quality service;

2) The physician must be responsible for providing continuous obstetric, pediatric, anesthesia, laboratory, and radiologic coverage, among other requirements;

3) One registered nurse on duty on each shift must be 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;

4) One registered nurse must be on duty for each shift assigned to the antepartum and postpartum areas; and,

5) A registered nurse who has had training and experience in neonatal nursing must be responsible for the nursing care in the nursery.

The Plumas Model. Plumas District Hospital (Plumas), located in Quincy, is a Critical Access Hospital licensed for 16 beds, with an average daily census of 5.5. Plumas also operates two Rural Health Clinics offering primary and specialty care. Plumas was the last frontier hospital in California to offer maternity services. Between 2017 and 2021, there was a fourfold increase in home births in Plumas County. Also during this time, there was a first occurrence of Plumas having to divert patients due to obstetric staffing shortages. In 2021, there were 52 hospitals births, 55 home births, and 59 out-of-county births to Plumas County residents. The decline in hospital births, and the difficulty in maintaining necessary staffing for a perinatal unit, forced Plumas to close its perinatal unit in 2022.

In July 2021, town hall forums were held to assess community needs, and the feedback was that Plumas County women want and need local maternity and childbirth services, with many expressing a desire for community birth options. Plumas states that the community feedback inspired hospital administration and medical staff to continue their efforts, which led to the creation of the Plumas Model. Under the Plumas Model, an Alternative Birth Center (ABC) would use the midwifery model to provide low-risk birthing. It would minimize costs by only being open for deliveries and classes. The 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, under existing law, 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 California law. The next closest hospital is 87 miles away, which is at least a 90 minute drive.

In much the same way 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.

ABCs. According to a March 2024 study by the Commonwealth Fund, *"Community-Based Models to Improve maternal Health Outcomes and Promote Health Equity,"* ABCs provide maternity care services for pregnancies free of active complications, or maternal and fetal factors that place the pregnancy at increased risk for complications. ABCs follows the midwifery model, which focuses on non-medicalized, low-intervention care. Compared to low-risk birthing people in hospitals, those who receive care in birth centers have lower rates of preterm birth, low birthweight, and Cesarean birth, and higher rates of breastfeeding and satisfaction with care. Furthermore, birth centers are generally community centered and focus on providing culturally competent care, resulting in fewer reports of discrimination compared to hospital-based systems. The model in this bill allows for the benefits of using ABCs, but also provides for a hospital nearby that is prepared to deal with minor complications.

According to the Author
One of the most significant health care access problems in his 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. The author states that he is 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. Studies show 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 departments, in small rural hospitals and at home. The author concludes that this model will provide a safer local alternative.

Arguments in Support
Partnership Health Plan, one of the sponsors of this bill states that Partnership is increasingly concerned about the expanding crisis of maternity care deserts in California, which has been exacerbated by the closing of labor and delivery units across the state over the last decade. Since 2012, 56 hospitals across the state have stopped delivering babies. Many of the hospitals that have ceased offering childbirth services are located in rural counties – such as those served by

Partnership – with already-limited access to healthcare and worse maternal outcomes than their urban counterparts. Partnership concludes that this bill will increase access to community based, culturally centered care for pregnant people *within* their communities – helping to ensure they remain engaged in perinatal care throughout their pregnancy and postpartum. Plumas District Hospital, also a sponsor, notes that this bill establishes a narrowly tailored pilot program for hospitals like Plumas that have already closed their labor and delivery units, to maintain perinatal services in our community.

Arguments in Opposition
None.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, DPH 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 DPH reports this bill will invoke the Project Approval Lifecycle (PAL) planning process. Although this project does not appear to be highly data-intensive, DPH 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. DPH bases its fiscal estimate on an assumption that 17 hospitals would participate in the pilot program. If fewer hospitals participate, the costs to DPH would be lower.

VOTES

SENATE FLOOR: 38-0-2
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Limón, Reyes

ASM HEALTH: 15-0-1
YES: Bonta, Chen, Addis, Aguiar-Curry, Caloza, Carrillo, Flora, Mark González, Krell, Patel, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Patterson

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Sanchez, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Ahrens, Pacheco, Pellerin, Solache, Ta, Tangipa

UPDATED

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