Office of Senate Floor Analyses
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UNFINISHED BUSINESS

Bill No: SB 669
Author: McGuire (D), et al.
Amended: 9/5/25 in Assembly
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/9/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/23/25
AYES: Caballero, Seyarto, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Dahle

SENATE FLOOR: 38-0, 5/29/25
AYES: 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
NO VOTE RECORDED: Limón, Reyes

ASSEMBLY FLOOR: 60-0, 9/9/25 – Roll call not available.

SUBJECT: Rural hospitals: standby perinatal services

SOURCE: Association of California Healthcare Districts (co-sponsor)
Partnership HealthPlan of California (co-sponsor)

DIGEST: This bill requires the California Department of Public Health (CDPH) to establish a ten-year pilot project to allow up to five critical access hospitals to establish standby perinatal services.

Assembly Amendments of 9/5/25 extend the pilot project from 5 years to 10 years, limited participation to critical access hospitals only and required the first hospitals

to be in Plumas County and Humboldt County; eliminate the prohibition on a hospital participating if they recently closed their perinatal service, but conditioned participation on an agreement with staff at the hospital or their representative if there is one; clarify physician responsibilities versus hospital responsibilities; and, revise the requirements regarding equipment, space, transfer agreements, and consultation arrangements, among other changes.

ANALYSIS:

Existing law:

1) Licenses and regulates health facilities by 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. [Health & Safety Code (HSC) §1250 and §1255]

2) 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)]

3) Requires an alternative birth center, as a condition of licensure, to meet certain requirements, including meeting the standards for certification established by the American Association of Birth Centers, or equivalent standards as determined by CDPH, and meet both of the following requirements:

   a) Be located in proximity, in time and distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide a cesarean section delivery, within 30 minutes from time of diagnosis of the emergency; and,
   b) Require the presence of at least two attendants at all times during birth, one of whom is required to be a physician, a licensed midwife, or a certified nurse-midwife. [HSC §1204.3]

This bill:

1) Requires CDPH to establish a ten-year pilot project, by July 1, 2026, with up to five critical access hospitals to allow participating hospitals to establish standby perinatal services. Requires the first two hospitals, if qualified, to be nonprofit and located in the County of Humboldt and the County of Plumas. Requires the three additional hospitals to be selected at any time if the application includes a

signed agreement from the exclusive employee representatives of the workforce that the pilot project would not adversely impact the workforce or includes an attestation that there is no existing exclusive employee representative.

2) Defines "standby perinatal services" as the provision of emergency obstetric and neonatal medical care to patients who are transferred from an alternative birth center, or who present to the hospital's emergency department with an urgent or emergent obstetric issue, in a specifically designated area of the hospital that is equipped and maintained at all times to receive patients and capable of providing physician, midwifery, and nursing services within a reasonable time not to exceed 30 minutes.

3) Requires CDPH to determine, within a reasonable time, whether hospitals requesting to participate in the pilot project meet specified requirements, including the following:

   a) Provide surgery and anesthesia as basic services of the hospital;
   b) Maintain capability for obtaining or performing timely blood gas, pH, and microbiologic analyses;
   c) Provide ability to maintain premixed infusions;
   d) Maintain a basic, comprehensive, or standby emergency medical service;
   e) Have a designated room for the standby perinatal service space, but permits a hospital to designate an existing room where the hospital may continue to provide general acute care services in that room when the rooms are not in use by perinatal services only if all remaining beds are occupied or a plan for using alternate space is approved by CDPH. Permits the operating room to serve as the delivery room in hospitals with a bed capacity of 25 or less, but prohibits the operating room from serving as the sole standby perinatal service space; and,
   f) Establish any additional requirements, in consultation with stakeholders, that CDPH deems necessary to protect patient safety.

4) Requires a hospital requesting approval to establish a standby perinatal service to comply with the most recent standards and recommendations for Level 1 (Basic Care) of the Levels of Maternal Care and Level 1 (Well Newborn Nursey) of the Neonatal Levels of Care, within the Guidelines for Perinatal Care developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

5) Requires a hospital requesting to establish a standby perinatal service to have the capacity for operative delivery, including caesarean section, and neonatal resuscitation and stabilization at all times.

6) Requires a hospital requesting to establish a standby perinatal service to have the ability, equipment, and supplies necessary to provide care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major disability, including, among other things, all of the following services:

   a) Administration of intravenous or intramuscular antibiotics, anticonvulsants, or uterotonic drugs, including oxytocin;
   b) Administration of antihypertensives;
   c) Manual removal of the placenta, and removal of retained products of conception;
   d) Basic neonatal resuscitation; and,
   e) Blood transfusions.

7) Requires a hospital requesting to establish a standby perinatal service to have capability for risk identification and determination of conditions necessitating consultation, referral, and transfer, as well as capabilities for stabilization and the ability to facilitate transfer or transport to a higher level of care at all times.

8) Requires a hospital requesting to establish a standby perinatal service to have the equipment and supplies of a normal perinatal unit, as specified in regulations, and in addition have all of the following equipment and supplies:

   a) A fetal heart rate monitor, with specified capabilities;
   b) Provision for oxygen and suction for the mother and infant;
   c) A ventilator assistance bag and infant masks of assorted sizes;
   d) A postpartum hemorrhage kit;
   e) Neonatal resuscitation supplies, including supplies for umbilical access for medications;
   f) Maternal steroid medications available for initial administration in the case of preterm labor while awaiting transport;
   g) A refrigerated medication storage unit in the standby perinatal service for uterotonic medications; and,
   h) A suction device appropriate for neonatal resuscitation.

9) Requires a hospital requesting to establish a standby perinatal service to define, in consultation with the medical staff, the responsibilities of the medical staff and administration associated with the standby perinatal services, and ensure that a provider in the hospital of perinatal services meets all requirements as set for in the medical staff bylaws, and the rules and policies of that facility.

10) Requires a hospital requesting to establish a standby perinatal services to ensure that 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 hospital, has overall responsibility of the service.

11) Requires the physician with overall responsibility for the service to be responsible for ensuring that contracts and agreements are in place and for the development of policies and procedures, as specified, including, among other things, the following:

    a) Developing policies and procedures required under specified provisions of existing regulations governing perinatal units;
    b) Admissions policies for infants transferred from an alternative birth center;
    c) Consultations, including real-time telemedicine services between the standby perinatal service and health care personnel from an intensive care newborn nursery and from a perinatal service, qualified and available at all times to provide maternal fetal medicine consultation;
    d) Formal arrangements for consultation or transfer of an infant to an intensive newborn nursery and a mother to a hospital with the necessary services for medical problems beyond the capability of the standby perinatal service;
    e) Current state newborn screening requirements;
    f) Standby perinatal service activation protocols;
    g) Condition-specific management protocols outlining best practices;
    h) Monitoring and checkoff to ensure that equipment stays in the standby perinatal service and does not outdate;
    i) Documentation standards for antepartum, intrapartum, postpartum, and newborn care;
    j) Arrangements for incidents of more than one patient requiring the use of the designated standby perinatal service space; and,
    k) Development by a committee of the medical staff of standardized procedures and order sets for pregnant patients presenting to the emergency department and for the standby perinatal service, and for neonates.

12) Requires a hospital requesting to establish a standby perinatal service, in consultation with the physician responsible for the service and other appropriate health care professionals, to do the following:

    a) Implement and maintain contracts, and transfer agreements as applicable, for any maternal or neonatal care outside of the scope of the standby perinatal service, including transfers to high levels of care, a blood bank, and ambulance transport and rescue;
    b) Develop a system for ensuring coverage to provide care for both the mother and the neonate, on call 24 hours a day for the standby perinatal service, including physician and nursing coverage onsite within 30 minutes, and a roster of physicians and certified nurse-midwives who have an agreement with the hospital who are available to provide emergency perinatal services;
    c) Have a registered nurse immediately available within the hospital to provide emergency maternal triage and infant resuscitation;
    d) Develop a roster of specialty physicians who have an agreement with the hospital who are available for consultation at all times;
    e) Ensure continued education for the medical staff, and document compliance with training program requirements for nursing staff, as specified, including biennial, week-long rotations at a Level II, III, or IV maternal or neonatal facility and participation in simulation-based training to reinforce response to obstetric emergencies; and,
    f) Annually verify and document all nursing competencies, as specified.

13) Requires a hospital requesting to establish a standby perinatal service to comply with existing licensed nurse-to-patient ratios for a combined labor/delivery/postpartum area of perinatal services.

14) Requires CDPH to develop a template to collect and evaluate data on safety, outcomes, utilization, and populations served under the pilot project, as specified, and to submit an evaluation to the Legislature and make this evaluation publicly available.

15) Requires CDPH to consult with relevant state departments and stakeholders on meeting the requirements of this bill, including representatives of hospitals, consumers, specified physician and nursing organizations, health plans, labor, and other health care professionals.

16) Permits CDPH to suspend or revoke approval of a hospital's participation in the pilot project if a hospital fails to meet the requirements of this bill or fails to ensure patient safety.

17) Permits a hospital to request program flexibility to meet the requirements of this bill in order to meet the particular capacities and needs of the hospital and community.

18) Permits CDPH to implement, interpret, or make specific this bill by means of an All Facilities Letter or similar instruction without taking regulatory action.

Comments

According to the author of this bill:

> One of the most significant health care challenges 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. I am authoring this bill to propose an innovative model to increase access in these maternal deserts. 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 *CalMatter*s, 56 hospitals in the state have stopped delivering babies since 2012, equal to 16% of all general acute care hospitals in California. 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 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, at a scheduled but possibly unnecessary cesarean procedure, in emergency departments in small rural hospitals and at home. This model will provide a safer local alternative.

Background

Levels of Maternal Care. This bill requires standby perinatal units participating in the pilot project to agree to provide "Level I maternal and neonatal services pursuant to ACOG Levels of Maternal Care." The Levels of Maternal Care describe the capabilities of different birthing facilities, ranging from the most basic

level of required capabilities to the most advanced. At the most basic level is an accredited birth center, which is defined as "care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth." Under California law, this type of facility is known as an alternative birth center, which can be licensed as a specialty clinic, or be offered as a service of a primary care clinic. Next up on the Levels of Maternal Care is Level I (Basic Care), which is defined as care of low- to medium-risk pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available. Level I facilities are required to have the capability and equipment, among other things, to begin emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits, and the ability at all times to initiate massive transfusion protocol, with process to obtain more blood and component therapy as needed. Level II (Specialty Care) is a Level I facility that additionally provides care for appropriate moderate-to-high-risk conditions. Level III (Subspecialty Care) adds more complex maternal medical conditions, obstetric complications, and fetal conditions with additional capabilities and health care providers, while Level IV (Regional Perinatal Health Care Centers) is at the top end, with on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses.

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 assure high quality service. Requires the physician to be responsible for providing continuous

obstetric, pediatric, anesthesia, laboratory, and radiologic coverage, among other requirements. Requires 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.

The proposed 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. According to Plumas, in the mid 1990's to the early 2000's, Plumas averaged 90 to 100 births per year, and had four family practice/obstetric providers. Beginning in 2010, however, hospital births trended down and community births trended up. 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 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. The third leg of the stool would be Plumas, which 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 alternative birth center 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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee, 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.

SUPPORT: (Verified 9/9/2025)

Association of California Healthcare Districts (co-sponsor)
Partnership HealthPlan of California (co-sponsor)
American Association of University Women of California
American College of Obstetricians & Gynecologists, District IX
California Hospital Association
California Medical Association
California Nurse Midwives Association
California Primary Care Association Advocates
California Special Districts Association
County Health Executives Association of California
First 5 California
Health Access California
Local Health Plans of California
March of Dimes

Planned Parenthood Affiliates of California
Plumas District Hospital
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 9/9/2025)

None received

ARGUMENTS IN SUPPORT: According to the author, this bill is co-sponsored by Partnership HealthPlan of California (Partnership) and the Association of California Healthcare Districts (ACHD). Partnership states that it has long been concerned about the growing crisis of maternity care deserts in California, exacerbated by the closing of labor and delivery units across the state. Since 2012, 56 hospitals have stopped delivery babies and people who live in rural counties, like those within Partnership's coverage area, have few options for labor and delivery. ACHD states that this bill establishes a narrowly tailored pilot program for hospitals, including district hospitals that have already closed their labor and delivery units or have never operated one, to restore perinatal services to their community. This bill takes a measured approach to ensure that, when appropriate, women will no longer have to time their deliveries to reach a distant facility but will instead have the option to safely give birth within their own communities. ACHD states that many California hospitals have the resources to maintain labor and delivery services. However, due to a declining birth rate, financial pressures, and workforce shortages, preserving this level of care requires innovative solutions. Plumas District Hospital states in support that in 2022, after 63 years, it made the difficult decision to suspend their labor and delivery services due to staffing and financial challenges. As a result, their laboring mothers must now travel 87 miles to the nearest obstetric unit. This bill offers a vital and innovative solution to address this critical need and give women the option to safely give birth within their own communities.

The ACOG, District IX writes in support that this bill responds to an urgent and growing crisis in rural California: the loss of hospital-based maternity care. As rural hospitals have faced workforce and funding challenges, maternity unit closures have left entire regions without local obstetric services, putting pregnant individuals at significant risk due to prolonged travel times. Research shows that maternal and neonatal outcomes worsen significantly for patients living more than 60 minutes from an open maternity unit, with outcomes deteriorating further with every additional hour of travel. This bill proposes a thoughtful, measured solution: a five-year pilot program to explore the feasibility of providing basic labor and delivery services and emergency obstetric care in designated areas of rural

hospitals in facilities that have not recently operated full maternity services. This bill includes comprehensive standards to ensure patient safety, staff qualifications, equipment readiness, and appropriate protocols for emergency transfer and care. ACOG states it especially appreciates the bill's alignment with Level I perinatal care standards as described in our Levels of Maternal Care framework, and we are grateful to the author and sponsors of this bill for engaging closely with ACOG during the drafting process. This collaboration has helped ensure that the facilities participating in the pilot project will be equipped with the necessary personnel, training, and infrastructure to achieve the best possible outcomes for birthing mothers and their infants. ACOG states that while a full operating maternity unit should always be the goal, this bill offers a promising path forward to reduce maternal health disparities in rural California and to reinstate a safe, accessible alternative for care in communities currently left behind.

The California Nurse-Midwives Association (CNMA) supports this bill to allow critical access and small rural hospitals to have trained staff and equipment on standby to receiving patients with urgent obstetric needs in coordination with a birthing center. CNMA states that for low-risk pregnancies, birthing centers are a high-quality and safe option, often providing care in communities with limited access. CNMA states that multiple studies have demonstrated that women who received care in a birth center throughout pregnancy, birth and postpartum were more likely to be satisfied when compared to those who received standard hospital maternity care. CNMA states that when families establish relationships with long-distance providers, the population seeking care in the local community declines, which in turn exacerbates challenges caused by declining patient volumes. CNMA states that current law requires a perinatal unit to have appropriate space, equipment, supplies and specifically trained medical staff including physicians and registered nurses on duty at all times. Meeting this standard is not always possible in remote maternity deserts. As a result, pregnant women either have to travel long distances to deliver in a hospital with a perinatal unit, deliver at home with a midwife, or find a birthing center within 30 minutes of a licensed perinatal unit. CNMA states this bill is an innovative mechanism to test a model that allows a small rural birthing center to be located in or near a rural hospital that has specially trained staff on call to care for complications, such as the need for cesarean or intensive care for the newborn. This will improve access to a local, community based alternative birthing center located in or near their community hospital. Rural women will no longer be at risk of being unable to access a birthing facility in a timely manner, which will ensure their safety and that of their child.

Prepared by: Vincent D. Marchand / HEALTH / (916) 651-4111
9/9/25 13:03:04

****** END ******