Date of Hearing: April 14, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1696 (Stefani) – As Amended March 16, 2026

SUBJECT: Emergency services and care: nurse-midwives.

SUMMARY: Clarifies that a nurse-midwife, as specified, does not require physician supervision when the nurse-midwife is providing emergency services and care within the scope of their authorized licensure. Specifically, **this bill**: States that consistent with 1) through 17) of existing law, below, nothing in bill is to be construed to require physician supervision of a nurse-midwife when the nurse-midwife is providing emergency services and care within the scope of their licensure.

EXISTING LAW:

1) States that the certificate to practice nurse-midwifery authorizes the holder to attend cases of low-risk pregnancy and childbirth and to provide prenatal care, intrapartum care, and postpartum care, including immediate care for the newborn, interconception care, family planning care, and care for common gynecologic conditions, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. Defines, "low-risk pregnancy" to mean a pregnancy in which all of the following conditions are met:

    a) There is a single fetus;

    b) There is a cephalic (head down) presentation at onset of labor;

    c) The gestational age of the fetus is greater than or equal to 37 weeks and zero days and less than or equal to 42 weeks and zero days at the time of delivery;

    d) Labor is spontaneous or induced; and,

    e) The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the certified nurse-midwife is not qualified to independently address. [Business and Professions Code (BPC) § 2746.5]

2) States that the certificate to practice nurse-midwifery authorizes the holder, pursuant to policies and protocols that are mutually agreed upon by a physician and surgeon, that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, and that are signed by both the certified nurse-midwife and a physician and surgeon, to do any of the following:

    a) Provide a patient with care that falls outside the scope of services specified in 1) above;

    b) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium (the muscular middle layer of the uterine wall); and,

c) Furnish or order a Schedule II or III controlled substance, including for patients that fall within the scope of services specified in 1) above. [*Ibid.*]

3) Authorizes, if a physician and surgeon assumes care of the patient, the certified nurse-midwife to continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, as indicated by the mutually agreed-upon policies and protocols signed by both the certified nurse-midwife and a physician and surgeon. [*Ibid.*]

4) Authorizes, after a certified nurse-midwife refers a patient to a physician and surgeon, the certified nurse-midwife to continue care of the patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon. [*Ibid.*]

5) Requires, if a nurse-midwife does not have in place mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon pursuant to 2) above, the patient to be transferred to the care of a physician and surgeon to do either or both of the following:

   a) Provide a patient with care that falls outside the scope of services specified in 1) above; and/or;

   b) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium. [*Ibid.*]

6) Authorizes, if after the certified nurse-midwife initiates the process of transfer pursuant to 5) above, for a patient who otherwise meets the definition of a low-risk pregnancy but no longer meets the criteria specified in 1) above, because the gestational age of the fetus is greater than 42 weeks and zero days, if there is inadequate time to effect safe transfer to a hospital prior to delivery or transfer may pose a threat to the health and safety of the patient or the fetus, the certified nurse-midwife to continue care of the patient consistent with the transfer plan described in 18) below. [*Ibid.*]

7) Authorizes a patient who has been transferred from the care of a certified nurse-midwife to that of a physician and surgeon to return to the care of the certified nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer from the care of the nurse-midwife pursuant to 5) above is resolved. [*Ibid.*]

8) States that the certificate to practice nurse-midwifery authorizes the holder to attend pregnancy and childbirth in an out-of-hospital setting if consistent with the provisions of 1) above. [*Ibid.*]

9) Specifies that the provision above will not be interpreted to deny a patient's right to self-determination or informed decision-making with regard to choice of provider or birth setting. [*Ibid.*]

10) States that the certificate to practice nurse-midwifery does not authorize the holder of the certificate to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version. [*Ibid.*]

11) Requires a certified nurse-midwife to document all consultations, referrals, and transfers in the patient record. [*Ibid.*]

12) Requires a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately. [*Ibid.*]

13) Authorizes a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained. [*Ibid.*]

14) States that the provisions above do not authorize a nurse-midwife to practice medicine or surgery. [*Ibid.*]

15) States that the provisions above should not be construed to require a nurse-midwife to have mutually agreed-upon, signed policies and protocols for the provision of services described in 1) above. [*Ibid.*]

16) Authorizes, notwithstanding any other law, subject to the discretion of a general acute care hospital (GACH), as defined in 18) below, or a special hospital specified as a maternity hospital, as defined in 19) below, and the medical staff bylaws of that facility, a hospital may grant privileges to a certified nurse-midwife, allowing them to admit and discharge patients upon their own authority, within their scope of practice, and in accordance with organized medical staff bylaws of that facility. [*Ibid.*]

17) Requires a certified nurse-midwife to disclose in oral and written form to a patient as part of a patient care plan, among other things:

    a) The specific arrangements for the referral of complications to a physician and surgeon for consultation. Prohibits the certified nurse-midwife from being required to identify a specific physician and surgeon;

    b) The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary, and recommendations for preregistration at a hospital that has obstetric emergency services and is most likely to receive the transfer; and,

    c) If, during the course of care, the patient is informed that the patient has or may have a condition indicating the need for a mandatory transfer, the certified nurse-midwife to initiate the transfer. [BPC § 2746.54]

18) Defines a GACH to mean a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. [Health and Safety Code (HSC) Section § 1250 (a)]

19) Defines a "special hospital" to mean a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity. [HSC § 120 (f)]

20) Requires, in regulations, a perinatal unit of a hospital to provide:

    a) Care for the patient during pregnancy, labor, delivery and the postpartum period;

    b) Care for the normal infant and the infant with abnormalities which usually do not impair function or threaten life;

    c) Care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major disability; and,

    d) Formal arrangements for consultation and/or transfer of an infant to an intensive care newborn nursery, or a mother to a hospital with the necessary services, for problems beyond the capability of the perinatal unit. [California Code of Regulations, Title 22, Division 5, Article 6, Section 70547)

21) Requires emergency departments (EDs), under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and also under similar provisions of state law (state EMTALA), to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay. Federal EMTALA imposes this requirement on any hospital that participates in Medicare. State EMTALA imposes this requirement on any hospital that operates an ED. [42 United States Code § 1395dd; HSC § 1317]

22) Defines "emergency services and care," under state EMTALA, as medical screening, examination, and evaluation by a physician to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. [HSC § 1317.1 (a)(1)]

23) Defines "emergency services and care," under state EMTALA, to also mean an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. Specifies that the care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a GACH, or to an acute psychiatric hospital. [HSC § 1317.1 (a)(2)]

24) Defines "emergency medical condition" to mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

    a) Placing the patient's health in serious jeopardy;

    b) Serious impairment to bodily functions; or,

    c) Serious dysfunction of any bodily organ or part. [HSC § 1317.1 (b)]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California families deserve high-quality, evidence-based maternity care that improves outcomes while reducing unnecessary costs. The author states that despite leading the nation in health care innovation, we continue to see rising maternal morbidity, persistent racial disparities, and unsustainable spending. Evidence consistently shows that midwifery care improves outcomes, reduces unnecessary interventions, and lowers costs. However, outdated regulatory structures limit the ability of the health care system to fully utilize this proven model of care. The author contends that this bill addresses inconsistencies in existing law enabling a more efficient, equitable, and patient-centered maternity care system. The author concludes that by aligning policy with evidence, this bill will improve outcomes for families across California while advancing health equity and fiscal responsibility.

2) **BACKGROUND.** Certified Nurse-Midwives (CNMs) are licensed registered nurses (RNs) with additional training in the field of obstetrics and certification by the American Midwifery Certification Board or an equivalent program. As a result of their additional training, they are considered advanced practice RNs. As a result of that training, CNMs are also specifically authorized to perform midwifery services and attend cases of low-risk pregnancies and childbirth. CNMs provide midwifery and nursing services in many settings, including the home, birth centers, clinics, and hospitals. California CNMs currently attend approximately 14% of births in California but could provide greater health care access with workforce expansion. Nurse-midwifery is a mandated Medi-Cal benefit but access to midwifery care across the state is highly variable. They are a key component of the 2025 California Department of Health Care Services' Birthing Care Pathway Report, a comprehensive care model road map for Medi-Cal members at a time when California is facing a worsening shortage of obstetric providers and labor and delivery units are closing around the state.

   According to a 2019 California Health Care Foundation report, "*California's Midwives: How Scope of Practice Laws Impact Care,"* mandatory physician supervision decreases access to care by superficially limiting the ability of licensed providers to act at the top of their license. According to a 2020 Legislative Analysts' Office report (LAO report), "*Analysis of California's Physician-Supervision Requirement for Certified Nurse-Midwives*," physician supervision is not well-defined and "unlikely to improve patient safety and quality." The LAO report notes that, "physician supervision" does not mean the physician must do any of the following: be physically present; examine the patient or ever meet the patient; sign or review any charts; or oversee patient care in any way.

   The California state legislature responded in 2020 by passing SB 1237 (Dodd) Chapter 88, Statutes of 2020 which established the parameters for the independent scope for CNMs and defines when a nurse-midwife can collaborate or must refer care to a physician, eliminating direct physician supervision of CNMs, with clear statutory delineation of when physician involvement is required, as noted in existing law, above.

   a) **EMTALA**. EMTALA was passed to address the problem of hospitals refusing to treat indigent, uninsured, or Medicaid patients, or "dumping" these patients by transferring them to county hospitals or other charity hospitals. Federal EMTALA obligates Medicare-participating hospitals that offer emergency services to provide a medical screening and treatment for an emergency medical condition, including active labor,

regardless of an individual's ability to pay. State EMTALA imposes its obligation on any hospital that operates an ED, and has similar requirements to federal EMTALA. Hospitals are required to provide stabilizing treatment for patients with an emergency medical condition. A patient is "stabilized" when the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the release or transfer of the patient.

Health and Safety code (HSC § 1317, existing law 22) above) mirrors federal EMTALA requirements, stating that any patient who comes to an emergency department must receive an appropriate medical screening exam (MSE) regardless of insurance status and ability to pay, among other things. The MSE is used to determine if there is in fact a medical emergency. An MSE involves the same skills that are core to nurse-midwifery care in other settings: conducting a medical history, performing a physical exam, ordering labs or imaging, when indicated.

"Emergency services and care" (ESC) is a regulatory term indicating that hospitals are obligated to provide care when a patient presents to the ED; it is not defined by the acuity of patient status.

b) Nurse Assessments. Nurse-midwives currently provide ESC evaluating pregnant patients who arrive at the hospital seeking urgent care without an appointment. The patients who present for ESC fall into three buckets: emergency medical condition, non-emergency medical condition, and active labor. Existing nurse-midwife scope of practice already provides the framework to provide ESC appropriate to the skills, training and qualifications of the midwife. The physician supervision requirement in state EMTALA (HSC § 1317.1) is unnecessary because nurse-midwives already have the level of physician involvement delineated in their scope of practice: policies and protocols signed by a physician, including delineation of "the parameters for consultation, collaboration, referral, and transfer of a patient's care." Patients evaluated to have emergency medical conditions are required to be immediately referred to a physician by BPC § 2746.5 (h)(1).

Not every patient who comes to an ED presents with a medical emergency. If a patient presents with a medical emergency, this is not appropriate for nurse-midwifery care. For those who are not suffering a medical emergency but require care within CNM current scope of practice, the CNM serves as a critical part of the care team - allowing the physicians to focus their time on those patients whose acuity requires their care. For those patients who present with non-emergency issues, CNMs can and should provide this care as intended by SB 1237– with policies and protocols with physicians in place, but not mandatory physician supervision. This bill removes the physician supervision requirement stated in the health and safety code leaving intact the policies and procedures for physician involvement already specified in BPC § 2746.5.

c) Labor and Delivery and Emergency Services. According to the California Hospital Association guidance regarding whether labor and delivery is considered an ED, "When and Where Does EMTALA Begin and End?" labor and delivery service is considered by the Centers for Medicaid and Medicare Services (CMS) to be a dedicated ED. Therefore, the labor and delivery service must comply with all of the EMTALA obligations. These include signage, central log, opening of medical records and on-call coverage, as well as policies for mental status exams, necessary stabilizing treatment and an appropriate

transfer (if required) for any individual who presents to the department seeking or in need of examination or treatment for any emergency medical condition.

CMS guidance (clarifying policies related to the Responsibilities of Medicare-Participating Hospitals in Treating Individual with Emergency Medical Conditions, final rule) states that, "…we note that the proposed definition would encompass not only what is generally thought of as a hospital's "emergency room" but would also include other departments of hospitals, such as labor and delivery departments and psychiatric units of hospitals, if these departments provide emergency psychiatric or labor and delivery services, or both, or other departments that are held out to the public as an appropriate place to come for medical services on an urgent, nonappointment basis."

d) **Access to maternity care in California.** Communities around California face a severe lack of access to reproductive health and maternity care. The California Hospital Association reports that between 2014 to 2024, more than 50 maternity units closed throughout the state. The maternity workforce shortage is one of three key drivers, with a projected shortage of 1,100 OB/GYNs in California by 2030. More recent data shows that there is a projected 20% shortage of OB/GYNs in California by 2035, which is considered "severely inadequate." Demonstrating the real-world impact, data from 2022 demonstrates that 46,000 California women age 18 to 44 lived in counties with no hospitals with obstetrics care or birth centers, and an additional 76,000 lived in counties with only one hospital with obstetrics care or a birth center. Simultaneously, maternal mortality rates in the state remain unacceptably high, with approximately 80% thought to be preventable.

e) **Disparities in maternity care.** Midwives play a critical role in advancing health equity, particularly in perinatal and reproductive health. Black and Indigenous birthing people in California experience significantly higher rates of maternal morbidity and mortality compared to white patients, driven by structural racism, implicit bias, and unequal access to high-quality care. Midwifery care has been shown to reduce interventions such as cesarean birth, preterm birth, and low birth weight—outcomes that disproportionately affect these communities. By increasing access to midwives, this bill supports a model of care that improves clinical outcomes where disparities are most pronounced. Of note, the UCSF Center for Health Equity recently included "access to midwifery care" as a strategy to improve person-centered care for Black birthing people.

3) **SUPPORT.** The California Nurse-Midwives Association (CNMA) is the sponsor of this bill and notes that Nurse-midwives are advanced practice clinicians who provide perinatal and reproductive health care. Most nurse-midwives provide direct patient care in hospital settings on labor and delivery units, evaluating and treating patients who present with a variety of pregnancy and postpartum health concerns. The triage area of a labor and delivery unit serves as an ED for pregnant and postpartum individuals. Individuals present to triage when they are experiencing contractions and want to know if they are in labor. They might also present with other urgent issues not appropriate for assessment in the clinic: severe headaches, nausea and vomiting, abdominal pain, or infection related to breastfeeding, for example.

CNMA states that when nurse-midwives provide care in labor and delivery triage units, this care falls under the category of "emergency services and care" and is regulated by California Health and Safety Code (HSC) §§ 1317-1317.10.4. This code ensures that people who need

emergency services and care are not refused treatment or improperly transferred because of their ability to pay, insurance status, or other non-medical reasons. These sections are California's core patient-protection laws for emergency care, similar in purpose to the federal EMTALA law. Under Title 22 of the California Code of Regulations, "Emergency Department" means any location in a hospital licensed to provide emergency medical services where those services are provided - which includes hospital labor and delivery triage units. Pregnant and early postpartum individuals will typically be instructed to bypass the ED and go directly to labor and delivery triage units for their "emergency services and care."

CNMA also notes that, currently, this code section requires that non-physicians must act under physician supervision when providing emergency services and care, including consultation and stabilization. However, the state removed the requirement of physician supervision for nurse-midwives in 2020 through SB 1237 (Dodd). This bill would update the Health and Safety Code to reflect nurse-midwives' current practice authority without physician supervision. CNMA concludes that this allows nurse-midwives and physicians to perform their work without unnecessary administrative barriers and is consistent with current California law for nurse-midwifery practice.

4) **OPPOSE UNLESS AMENDED.** The California Chapter of the American College of Emergency Physicians (California ACEP) is opposed to this bill unless it is amended to not apply in the ED. California ACEP states that Section 2746.5 of BPC grants independent practice to CNMs in low-risk situations. Specifically, subdivision (a) states: "the certificate to practice nurse-midwifery authorizes the holder to attend cases of low-risk pregnancy and childbirth." California ACEP contends that it was not intended to grant CNMs independent practice in the ED. In fact, subdivision (h)(1) specifically states: "A certified nurse-midwife shall refer all emergencies to a physician and surgeon immediately." California ACEP argues that patients arrive at EDs with high-risk conditions. By its very definition, when a patient comes to an ED they are seeking emergency care. That care does not fall within the scope of independent practice contemplated or authorized by B&P Code Section 2746.5. California ACEP explains that there are many valuable members of the health care team in EDs and that this model delivers effective care to millions of Californians because it is team-based and physician-supervised.

5) **PREVIOUS LEGISLATION.**

   a) SB 667 (Dodd) Chapter 497, Statutes of 2023 clarifies a CNM's authority to treat and provide care for common gynecologic conditions; permits a CNM to admit or discharge a patient if a CNM has privileges at a general acute care hospital, as specified; clarifies that a CNM is a practitioner for purposes of certifying disability; and includes a CNMs as a laboratory director for purposes of performing specified laboratory tests, among other technical changes.

   b) SB 1237 (Dodd) Chapter 88, Statutes of 2020 established the parameters for the independent scope for certified nurse midwives and defines when a CNM can collaborate or must refer care to a physician.

   c) SB 520 (Caballero) Chapter 601, Statutes of 2025 creates the California Nurse-Midwifery Education (CNME) Fund in the Department of Health Care Access and Information (HCAI) for the purpose of establishing California-based, master's level nurse-midwifery

education programs. Requires HCAI to administer the fund, which will receive money from the General Fund upon appropriation.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Nurse Midwives (sponsor)
Access Reproductive Justice
American Nurses Association/California
Aria Medical
California Association of Nurse Anesthesiology (CANA)
California Clinical Nurse Specialist Association
California Women's Law Center
Gender Equity Policy Institute (UNREG)
National Health Law Program
Nurses for Sexual & Reproductive Health
Reproductive Freedom for All California

Opposition

None on file

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