ASSEMBLY THIRD READING
AB 1696 (Stefani)
As Amended May 18, 2026
Majority vote

SUMMARY

Clarifies that a nurse-midwife, as specified, does not require physician supervision *in the labor and delivery unit, obstetric triage, or dedicated emergency obstetric evaluation unit of a general acute care hospital* when the nurse-midwife is providing emergency services and care within the scope of their authorized licensure, *or when the nurse-midwife is specifically requested by the treating physician to provide obstetric consultation.*

Major Provisions

COMMENTS

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.

Emergency Medical Treatment and Labor Act (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 Emergency Department (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) Section 1317 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.

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 Section 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 Business and Professions Code (BPC) Section 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 Section 2746.5.

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."

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 University of California, San Francisco Center for Health Equity recently included "access to midwifery care" as a strategy to improve person-centered care for Black birthing people.

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.

Arguments in 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 HSC Sections 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.

Arguments in Opposition
The California Chapter of the American College of Emergency Physicians (California ACEP), is opposed to this bill and states that, while it is intended to bring conformity with independent practice rights that were granted to CNMs by the passage of SB 667 (Dodd), Chapter 497, Statues of 2023, as drafted AB 1696 could have application in the ED. California ACEP notes that Section 2746.5 of the BPC as amended in 2023 by SB 667 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" (emphasis added). 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 contends 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 BPC Section 2746.5.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, no state costs.

VOTES

ASM HEALTH: 15-1-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Schiavo, Sharp-Collins, Stefani
NO: Sanchez

ASM APPROPRIATIONS: 12-0-3
YES: Wicks, Hoover, Arambula, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Solache, Ta
ABS, ABST OR NV: Dixon, Muratsuchi, Tangipa

UPDATED

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