SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 1696
AUTHOR: Stefani
VERSION: May 18, 2026
HEARING DATE: June 24, 2026
CONSULTANT: Vincent D. Marchand

SUBJECT: Emergency services and care: nurse-midwives

SUMMARY: Prohibits provisions of law requiring hospitals to stabilize patients with an emergency medical condition, or when they are in active labor, without regard to ability to pay, from requiring supervision of a certified nurse-midwife in the labor and delivery unit, obstetric triage, or dedicated emergency obstetric evaluation unit, when the nurse-midwife is practicing within their scope of practice.

Existing law:

1) Licenses and regulates hospitals, including a general acute care hospital, by the California Department of Public Health (CDPH). Permits general acute care hospitals, in addition to the basic services all hospitals are required to offer, to be approved by CDPH to offer special services, including, among other services, an emergency department (ED). [HSC §1250 and §1255, et seq.]

2) Requires 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. Both federal and state EMTALA impose this requirement on any hospital that operates an ED. [42 USC §1395dd and HSC §1317]

3) Defines "emergency services and care," under state EMTALA, as medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate persons under the supervision of 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)]

4) Defines "active labor," for purposes of state EMTALA, as labor at a time which either of the following would occur: (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or, (2) a transfer may pose a threat to the health and safety of the patient or the fetus. [HSC §1317.1(c)]

5) Prohibits a person needing emergency services and care from being transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless certain conditions are met, including that the person is examined and evaluated by a physician, including, if necessary, consultation prior to transfer, and also has been provided with emergency services so that it can be determined, within reasonable medical probability, that the transfer will not create a medical hazard to the person. [HSC §1317.2]

6) Defines "consultation," for purposes of state EMTALA, as the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. Specifies "consultation" includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician, or by other appropriate licensed persons acting within their scope of license under the supervision of a consulting physician, who is qualified to give an opinion or render the necessary treatment. [HSC §1317.1(i)]

7) Specifies, for purposes of state EMTALA, that a patient is "stabilized" when, in the opinion of the treating physician, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician, 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, or occur during, the release or transfer of the patient. [HSC §1317.1(j)]

8) Licenses and regulates nurses, including certified nurse-midwives (CNMs) through the Board of Registered Nursing. 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, as specified. [BPC §2700 et seq. and §2746.5]

9) Defines "low-risk pregnancy," for purposes of the scope of practice of CNMs, as a pregnancy in which all of the following conditions are met:
   a) There is a single fetus;
   b) There is cephalic presentation at the onset of labor;
   c) The gestational age of the fetus is between 37 and 42 weeks at the time of delivery;
   d) Labor is spontaneous or induced; and,
   e) The patient has no preexisting disease or condition, arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the CNM is not qualified to independently address. [BPC §2746.5]

This bill: Prohibits state EMTALA from requiring physician supervision of a CNM in the labor and delivery unit, obstetric triage, or dedicated emergency obstetric evaluation unit, when the CNM is providing care to the extent authorized by their scope of practice, or when the CNM is specifically requested by the treating physician to provide obstetric consultation, notwithstanding provisions of state EMTALA that permit other appropriate licensed persons, acting within their scope of license under the supervision of a physician, to examine and evaluate, provide consultation, or determine whether a patient is stabilized.

FISCAL EFFECT: According to the Assembly Appropriations Committee, no state costs.

PRIOR VOTES:

Assembly Floor:	74 - 1
Assembly Appropriations Committee:	12 - 0
Assembly Health Committee:	15 - 1

COMMENTS:

1) *Author's statement.* According to the author, California is facing a worsening shortage of obstetric providers; labor and delivery units are closing around the state. Mandatory physician supervision decreases access to care by superficially limiting the ability of nurse-midwives to act at the top of their license and increases costs by requiring redundancy in care

delivery. Further, per the Legislative Analyst's Office Analysis of California's Physician-Supervision Requirement for Certified Nurse-Midwives, physician supervision is "unlikely to improve patient safety and quality." The California state Legislature responded in 2020 via SB 1237 (Dodd) by eliminating physician supervision of nurse-midwives, with clear statutory delineation of when physician involvement is required. However, the Health and Safety Code still requires that nurse-midwives have physician supervision for patients who come to the hospital and require the EMTALA-mandated medical screening and evaluation. This means that a nurse-midwife can evaluate and treat the same patient for the same issue without physician supervision if they are in the clinic or admitted to the hospital, but is required to have physician supervision if the care episode falls under EMTALA. This causes confusion for patients, for nurse-midwives, and for hospital staff. This bill is needed to eliminate confusion about when a patient is appropriate for nurse-midwife care or when the nurse-midwife requires physician supervision.

2) *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 their medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from their release or transfer. If a hospital is unable to stabilize a patient within its capability, the patient is required to be transferred to an appropriate facility with the necessary specialized treatment services. Once a patient is stabilized, if they need post-stabilization care, the hospital will typically seek more information about the medical history of the patient, including whether they have insurance.

3) *EMTALA definition of emergency department includes labor and delivery units.* As described above, both state and federal EMTALA apply to hospitals with an ED. In implementing regulations, the Centers for Medicare and Medicaid Services (CMS) define "dedicated emergency department" as any department or facility of the hospital that either: (1) is licensed by the state as an ED; (2) held out to the public as providing treatment for emergency medical conditions; or (3) one-third of visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis. In explaining this definition, CMS stated that the third prong of this definition includes individuals who may present as unscheduled ambulatory patients to units, including labor and delivery units or hospital urgent care centers, where patients are routinely evaluated and treated for emergency medical conditions. In other words, because pregnant patients regularly go into labor and come to the labor and delivery unit of a hospital on an unscheduled basis, this makes the labor and delivery unit an "emergency department" under EMTALA.

   The author and sponsor point out that because EMTALA covers labor and delivery units where CNMs work, CNMs should be able to provide the necessary EMTALA-required medical screening, consultation, or determination of whether the patient is stable enough for discharge or transfer without supervision, as long as it is within their scope of practice (low-risk pregnancies).

4) *Background on CNMs.* CNMs are advanced practice registered nurses who have specialized education and training to provide primary care, prenatal, intrapartum, and postpartum care. These individuals are licensed by the California Board of Registered Nurses (BRN), have acquired additional training in the field of obstetrics, and are certified by the American College of Nurse Midwives. In order to obtain a certificate to practice as a CNM, the applicant must provide proof to the BRN that they have either graduated from a BRN approved program in nurse-midwifery or satisfied equivalent standards as set forth in the BRN's regulations. The nurse-midwifery certificate authorizes the CNM to attend cases of *low-risk* pregnancy and childbirth, as well as immediate care for the newborn, along with family planning and interconception care.

   Prior to 2020, CNMs were required to practice under the supervision of a physician under standardized procedures and protocols. Standardized procedures were developed collaboratively by nurses, physicians, and the administration of the organized health care system. While supervision by a physician was required for CNMs to provide patient care, that supervision did not require the physical presence of a physician, and physicians were limited to supervising no more than four CNMs at a time.

   SB 1237 (Dodd, Chapter 88, Statutes of 2020) revised the current practice authorization for CNMs. SB 1237 eliminated the requirement for a CNM to practice midwifery according to standardized procedures or protocols with a physician. By doing this, SB 1237 did not change the scope of work that a CNM could perform, but permitted a CNM to perform their work without physician supervision.

5) *Prior legislation.* 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; clarified that a CNM is a practitioner for purposes of certifying a disability; and, includes CNMs as a laboratory director for purposes of performing specified laboratory tests, among other technical changes.

   SB 1237 (Dodd, Chapter 88, Statutes of 2020) removes the requirement for a CNM to practice midwifery according to standardized procedures or protocols with a physician; revised the provisions defining the practice of midwifery; authorizes a CNM to attend cases out of a hospital setting; authorizes a CNM to furnish or order drugs or devices in accordance with standardize protocols with a physician; requires a CNM to provide specified disclosures to a patient; and, establishes new reporting a data collection requirements.

   SB 233 (Pavley, Chapter 333, Statutes of 2011) clarifies the state EMTALA law to explicitly permit appropriate licensed personnel to perform consultations and treatment in an emergency department if within their existing scope of practice.

6) *Support.* This bill is sponsored by the California Nurse-Midwives Association, which states that most CNMs 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, such as severe headaches, nausea and vomiting,

abdominal pain, or infection related to breastfeeding. When CNMs provide care in labor and delivery triage, this care falls under the category of "emergency services and care," regulated by the state EMTALA provisions of state law. These sections are California's core patient-protection laws for emergency care, and ensure people who need emergency services and care are not refused treatment or improperly transferred because of their ability to pay, insurance status, or other nonmedical reasons. 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 this requirement of physician supervision for CNMs in 2020, and this bill would update the law to reflect CNMs current practice authority.

SUPPORT AND OPPOSITION:

Support: California Nurse-Midwives Association (sponsor)
Access Reproductive Justice
American Nurses Association/California
Aria Medical
California Association for Nurse Practitioners
California Association of Nurse Anesthesiology
California Clinical Nurse Specialist Association
California Latinas for Reproductive Justice
California Women's Law Center
Gender Equity Policy Institute
March of Dimes
National Health Law Program
Nurses for Sexual & Reproductive Health
Reproductive Freedom for All California
Western Center on Law & Poverty, Inc.

Oppose: None received

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