House Bill 1468 – Hospitals – Patients in Active Labor – Safe Discharge Labor Plans

Position: ***Oppose***
March 11, 2026
House Health Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment on House Bill 1468.

This bill would prohibit hospitals from discharging or transferring a patient in active labor unless the hospital and the patient complete a "safe discharge labor plan." Maryland hospitals share the goal of ensuring that pregnant patients receive safe, respectful, and high-quality care. Hospitals already follow established clinical standards and federal requirements, including the Emergency Medical Treatment and Active Labor Act (EMTALA) governing the evaluation and treatment of patients who present in labor and the Maryland Perinatal System Standards which set additional regulatory requirements for risk-appropriate, high-quality care for mothers and newborns. These longstanding frameworks ensure that patients are appropriately assessed, stabilized, and treated according to accepted standards of obstetric practice. Under EMTALA, hospitals cannot discharge or transfer a patient in active labor unless the patient has been stabilized or a transfer to another facility is required to provide necessary care. These protections ensure that pregnant patients receive immediate medical attention and are not discharged in unsafe circumstances.

While we understand the concerns that motivated the introduction of this legislation, hospitals have several concerns regarding the bill's implementation and potential unintended consequences.

First, the bill's definition of "patient in active labor" relies broadly on signs or symptoms of labor according to generally accepted obstetric practice. In clinical settings, labor progresses through multiple stages and presentations, and determining when a patient is truly in active labor requires professional medical judgment. This definition may create uncertainty regarding when the requirements of a safe discharge labor plan apply.

Second, the bill would require hospitals to complete a standardized discharge plan even in situations where a clinician determines that discharge is medically appropriate. It is rarely the case, if at all, that hospitals discharge or transfer patients in active labor outside of emergency transfers. However, it is common for hospitals to encounter patients experiencing latent or false labor, where the individual may still be hours, or even days, away from active labor. In these cases, after clinical evaluation and monitoring, providers may determine that it is safe for the patient to return home. These patients are sent home with clear guidance on warning signs to look out for, instructions on when to return for reassessment, and how to contact their provider if

symptoms progress. Hospitals also maintain extensive documentation of clinical assessments and discharge instructions in the medical record as part of standard practice. Requiring a standardized formal discharge plan in every such instance could create unnecessary confusion regarding clinical decision-making and the applicability of existing laws, as well as increase administrative requirements without improving patient safety.

Third, the legislation proposes extensive documentation and record-retention requirements, including assessing the distance between the hospital and intended destination and maintaining discharge labor plans for at least 21 years, that further add administrative steps that may divert staff time and attention away from direct patient care in labor and delivery units that already operate under significant clinical and operational demands.

There are also operational realities related to situations in which a patient chooses to leave the hospital against medical advice. The bill does not clearly address how hospitals should comply with the discharge plan requirements if a patient declines to participate in the process or leaves prior to completing the documentation.

Finally, the bill includes new training and reporting requirements in areas where hospitals are already engaged in ongoing statewide efforts and quality improvement initiatives focused on reducing disparities and improving maternal and child health outcomes.

By imposing additional statutory requirements that overlap with existing federal law and established clinical protocols, HB 1468 risks creating duplicative documentation requirements without necessarily enhancing patient protections. For these reasons, MHA respectfully requests an unfavorable report on HB 1468.

For more information, please contact:
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