SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Dr. Aisha Wahab, Chair
2025 - 2026 Regular

Bill No:	SB 1271	**Hearing Date:**	April 13, 2026
Author:	Reyes		
Version:	March 25, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Midwifery: workforce data: availability to be a clinical preceptorship

SUMMARY: Requires the Medical Board of California (MBC), in complying with workforce data collection, to request licensed midwives (LMs) to provide MBC with information about the LM's ability to serve as a clinical preceptor and requires MBC to provide the information quarterly to the Department of Health Care Access and Information (HCAI).

NOTE: *This bill is double-referred to the Senate Committee on Health, second.*

Existing law:

1) Requires health care professional licensing boards to request the following data from licensees at least biennially for future workforce planning (other than specified boards which are required to collect the information):

   a) Anticipated year of retirement

   b) Area of practice or specialty

   c) City, county, and ZIP Code of practice

   d) Date of birth

   e) Educational background and the highest level attained at time of licensure or registration

   f) Gender or gender identity

   g) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration

   h) Languages spoken

   i) National Provider Identifier

   j) Race or ethnicity

k) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice

l) Work hours

m) Sexual orientation

n) Disability status (Business and Professions Code (BPC) § 502)

2) Requires boards or the Department of Consumer Affairs on boards' behalf to provide the information to the Department of Health Care Access and Information (HCAI). (Id.)

3) Establishes HCAI and requires HCAI to collect, analyze, and publish data about health care workforce and health professional training; identify areas of health workforce shortages; and provide scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need. Establishes the Health Professions Education Foundation (HPEF) within HCAI to, among other functions, develop criteria for evaluating applicants for various scholarships and loans. (Health and Safety Code (HSC) §127000, et seq. and §127750, et seq.)

4) Requires HCAI, as part of the Midwifery Workforce Training Act, to establish a program for training certified nurse-midwives (CNMs) and LMs in accordance with the global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives, in order to increase the number of students receiving quality education and training as a CNM or as a LM. (HSC §128298(b)(1))

5) Requires HCAI to only contract with programs that train CNMs and programs that train LMs that, at minimum, include, or that intend to create, a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and that are organized to prepare program graduates for service in those neighborhoods and communities, or that seek to recruit and retain racially and ethnically diverse students, underrepresented groups, or people from underserved or historically marginalized communities. (HSC §128298(b)(2))

6) Requires HCAI, upon appropriation from the Legislature, to administer funding for a statewide study on midwifery education conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that includes:

a) an evaluation of status and trends in midwifery education in California and the U.S.

b) a financial sustainability plan, including long-term education program financing, cost of educating midwives in California, and the options for financial stability of

midwifery education, including assessing available state and federal funding resources to cover specified students' costs

c) identifying and proposing pathways to diversify the midwifery student pipeline, including assessing the opportunities, challenges, and support needs of prospective students, current students, and preceptors

d) Identifying institutions and programs of study that are equipped to house midwifery education programs, as well as viable education programs that can serve both rural and urban geographic areas

e) identifying sites for interprofessional education between resident obstetricians and midwives, as well as considering ways to allow CNMs and LMs to train together, with separate exit requirements specific to their path;

f) Ensuring proposed solutions for midwifery education meet the needs of California birthing families and future midwives

g) An assessment of jobs available for new graduates, and projected growth. (HSC § 128300)

7) Establishes the Licensed Midwifery Practice Act of 1993, which provides for the regulation and licensure of LMs by the MBC. (BPC § 2505)

8) Requires the MBC to create and appoint a Midwifery Advisory Council consisting of licensees of the board and members of the public who have an interest in midwifery practice, including, but not limited to, home births, of which half must be LMs. (BPC § 2509)

9) Specifies that a person is qualified for licensure as a LM when they either:

a) Successfully complete a three-year postsecondary midwifery education program accredited by an accrediting organization approved by MBC and successfully complete a comprehensive licensing examination adopted by MBC which is equivalent, but not identical, to the examination given by the American College of Nurse Midwives

b) Successfully complete an educational program MBC determines satisfies this criteria. (BPC § 2512)

10) Specifies that an approved LM education program must offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. Requires an applicant to demonstrate, by practical examination, clinical competencies. Requires MBC to approve a midwifery education program's credit by examination policy. Requires completion of clinical experiences to be verified by a LM or CNM, and a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery. Requires physicians and surgeons, LMs, and CNMs who participate in the verification and evaluation of an applicant's clinical experiences must show evidence of current practice. (BPC § 2513)

11) Requires each LM who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting to annually report information to HCAI on the number of clients the LM served; the number by county of live births the LM attended as a primary caregiver; information by county about fetal demise, infant deaths, and maternal deaths; the number of women whose care was transferred to another health care practitioner; the number, reason, and outcome for elective or urgent or emergency hospital transports and; other information about planned out-of-hospital births. (BPC § 2516)

This bill:

1) Requires MBC, in complying with data collection efforts for licensees pursuant to BPC § 502, to request LMs to provide MBC with the following and provide the information quarterly to HCAI:

   a) The LM's eligibility to serve as a clinical preceptor for student midwives enrolled in a midwifery education program approved by MBC, including whether they have met the minimum requirements to become a clinical preceptor, as well as whether the LM is currently available, or anticipates becoming available within the next two years, to serve as a clinical preceptor for student midwives and the primary practice setting or settings the LM would offer to serve as a clinical preceptor, including, but not limited to, home births, freestanding birth centers, hospital-based or integrated maternity settings, rural or frontier community settings, or federally qualified health centers.

   b) The maximum number of student midwives the LM is currently able to supervise concurrently and the county or counties in which the LM practices and would be available for clinical preceptorship.

   c) The primary reason or reasons a LM is not available if they tell MBC they are not available to serve as a clinical preceptor.

2) Requires HCAI, on or before January 1, 2028, to submit a report to the Legislature detailing the findings from this information.

3) States that the limitation on the public's right of access to public information this bill creates by requiring that only aggregated data be provided is necessary in order to protect the privacy of licensees while also gathering useful workforce data.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Reproductive Health Rights and Justice Team from the Women's Foundation California Solis Policy Institute is the sponsor of this bill. According to the Author, "despite their importance, the current system does not adequately support this training pathway. A shortage of preceptors, limited mechanisms to identify them, and demographic barriers often force trainees to complete their clinical training out of state. While research shows strong outcomes for patients

receiving midwifery care, a fragmented training pipeline creates structural barriers, particularly for communities of color and rural communities, and undermines efforts to build a diverse workforce. To address this gap, SB 1271 allows LMs, at the time of licensure or renewal, to voluntarily complete a survey assessing their capacity to serve as preceptors. By supporting more comprehensive data, SB 1271 will help the state develop data-informed solutions, identify barriers to preceptorship, and guide targeted incentives.

The Author adds that currently, licensed midwives are required to undergo a preceptorship with a registered preceptor midwife, but there are no incentives or compensation structures for midwives who serve in this preceptor role. Additionally, the current system does not have any established infrastructure to match students with available preceptors. As a result, these conditions have created significant barriers to access specialized care and regional disparities which disproportionately impacts BIPOC and rural areas. An expansion to data collection that covers eligibility, availability, capacity, practice setting and barriers to precepting as SB 1271 suggests would support the longevity of the field, reveal realistic measures to empower the profession, and encourage the workforce to be reflective of the diverse communities they serve.

2. **Background.**

Licensed Midwives. MBC regulates licensed midwives under the Licensed Midwifery Practice Act of 1993, which became effective January 1, 1994 at a time that MBC also had oversight for a multitude of allied health professions. While many other health professions later developed their own regulatory boards, MBC continues to have jurisdiction over this category of professionals. A licensed midwife (LM) is an individual who has been issued a license by MBC to practice midwifery. LMs who have achieved the required educational and clinical experience in midwifery (including completing a three-year postsecondary education program in an accredited midwifery school approved by the MBC) or met the challenge requirements (obtaining credit by examination for previous education and clinical experience – as of January 1, 2015, new LMs may not substitute clinical experience for formal didactic education), must pass the North American Registry of Midwives' comprehensive examination. After successful completion of this examination, prospective applicants are designated as a "certified professional midwife" and are eligible to submit an application for licensure as a LM.

LMs are authorized to attend cases of normal pregnancy and childbirth, as defined in statute, and to provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother and immediate care for the newborn. They are also authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to the practice of midwifery and consistent with their scope of practice. LMs can practice in a home, birthing clinic or hospital environment.

When the Licensed Midwifery Practice Act of 1993 was first enacted, LMs were required to practice under the supervision of physicians. AB 1308 (Bonilla, Chapter 665, Statutes 2013) removed the statutory physician-supervision requirement, but licensed midwives remain subject to statutory limits requiring consultation, referral,

or transfer when a client's condition falls outside normal pregnancy and childbirth. AB 1308 specified that a midwife may assist in "normal" pregnancy and birth, defined through regulations. SB 407 (Morrell, Chapter 313, Statutes of 2015) authorized a health care provider to employ or contract with LMs for providing comprehensive perinatal services in the CPSP.

LMs do not have member representation on MBC, rather, BPC Section 2509 authorizes MBC to create a Midwifery Advisory Council (MAC) and appoint its members consisting of LMs and members of the public, specifically at least half of the MAC members are LMs, and it includes one physician and two public members. The MAC makes recommendations on matters specified by MBC and MBC holds all authority to take action regarding the licensure and regulation of midwives in California. Members of the MAC, individual LMs, and state midwifery professional associations have called for LMs to be regulated by a separate board within the DCA. In general, these stakeholders argue that LMs and the physician community have incompatible approaches to providing care, therefore, it is inappropriate for LMs to be regulated by MBC.

The fees collected by LMs to fund MBC's oversight of the profession are deposited into a LM Fund administered by MBC. LMs submit an application and initial license fee of $450 and have a biennial renewal fee of $300. The renewal fee comprises almost 80 percent of the fees received in the LM Fund.

Midwifery Workforce. According to a February 2025 issue brief from the California Health Care Foundation (CHCF) *Midwives Speak: Integration Challenges in California's Health System*, midwives play a critical role in the maternity care workforce by providing comprehensive care during pregnancy, labor, birth, and the postpartum period, often serving as the primary birth attendant for low-risk pregnancies. The midwifery model of care emphasizes respectful, relationship-based, and person-centered care, supporting the physiologic process of labor and birth with minimal intervention unless clinically indicated. CHCF also notes that effective midwifery care includes appropriate consultation with obstetrician/gynecologists and timely transfer to physician care when complications arise or surgical intervention is required.

In California, two categories of midwives provide this care: LMs and nurse-midwives (NMs), who are regulated by the California Board of Registered Nursing and practice primarily in clinics and hospitals. Although their training pathways and typical practice settings differ, both provide care centered on pregnancy, childbirth, postpartum care, family planning, and newborn care, while NMs also provide broader sexual and reproductive health services. Nationally, certified nurse-midwives are legally recognized in all 50 states and the District of Columbia.

Recent CHCF workforce data published in October 2024, *California's Midwife Workforce: Demographics*, highlights both the importance of midwives and ongoing capacity challenges in California. In 2023, California had 1,160 nurse-midwives and 458 licensed midwives with active California licenses and California addresses; however, only 30 practicing midwives per 10,000 births statewide, with significant regional variation. The report showed that midwife-attended births have increased

over time, rising from 8.4 percent of California births in 2012 to 12.8 percent in 2022.

While California law continues to require completion of a MBC-approved midwifery education program for licensure as a LM, the number of such programs is limited, and most are out-of-state or distance-learning programs with California-based clinical training. Many previously approved schools are no longer in operation, and as of recent workforce analyses, California has had little to no in-state accredited LM programs. Recent publications also highlight these training-capacity challenges. CHCF reported in 2024 that, in addition to LM program availability limitations, the state has only two accredited NM education programs, one of which was not admitting students.

3. **Arguments in Support.** The Around-Birth Collective writes that "preceptors are experienced maternity providers who play a critical role in training and mentoring incoming LMs- bridging their academic learning with hands-on clinical experience. Despite being a required step towards licensure, between the preceptor shortage and scarce methods to find them, many students are left to independently navigate a fragmented inaccessible system. As a result, many trainees rely on out of state programs to complete their credentials. This training bottleneck has contributed to significant structural barriers that limit access for rural and diverse communities to get involved in the profession and from receiving the specialized care they deserve. SB 1271 provides a practical and low burden solution to further understand the barriers impacting the midwifery pipeline. An expansion to data collection to include preceptor availability, capacity, practice setting and barriers to precepting will support the longevity of the field, ensure the profession is reflective of the diverse communities they serve, and improve birth outcomes across California."

SUPPORT AND OPPOSITION:

Support:

Around-Birth Collective

Opposition:

None received

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