Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1271 (Reyes) – As Amended June 9, 2026

SENATE VOTE: 39-0

SUBJECT: Midwifery: workforce data: availability to be a clinical preceptorship.

SUMMARY: Requires the Medical Board of California (MBC), by April 1, 2027, to request certain information from a licensed midwife (LM) related to their availability to serve as a clinical preceptor for student midwives enrolled in a midwifery education program. Requires the MBC to provide the information to the Department of Health Care Access and Information (HCAI) for the purpose of statewide midwifery workforce planning, analysis, and public reporting. Requires HCAI to submit a report to the Legislature on or before January 1, 2029. Specifically, **this bill**:

1) Requires the MBC to request all of the following, as applicable, from an LM in the form and manner prescribed by the board:

    a) The LM's eligibility to serve as a clinical preceptor for student midwives enrolled in a midwifery education program approved by the MBC, including whether they have met the minimum requirements to become a clinical preceptor;

    b) If the LM responds that they are eligible to serve as a clinical preceptor pursuant to a) above, both of the following:

        i) Whether the licensed midwife is currently available, or anticipates becoming available within the next two years, to serve as a clinical preceptor for student midwives; and,

        ii) The primary practice setting or settings in which 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;

    c) If the LM responds that they are currently available, the maximum number of student midwives the LM is currently able to supervise concurrently and the county or counties in the state in which the LM currently practices and within which they would be available for clinical preceptorship; and,

    d) If the LM responds that they are not currently available, the primary reason or reasons for their unavailability.

2) Requires the MBC to maintain the confidentiality of the information it receives from LMs under this bill and to only release information in an aggregate form that cannot be used to identify an individual.

3) Requires the MBC to quarterly provide the individual licensed midwife data it collects to HCAI in a manner directed by HCAI for the purpose of statewide midwifery workforce

planning, analysis, and public reporting. Requires HCAI to maintain the confidentiality of the LM information it receives and to only release information in an aggregate form that cannot be used to identify an individual LM.

4) Requires HCAI, on or before January 1, 2029, to submit a report to the Legislature detailing the findings of HCAI based on the information received pursuant to 3) above.

5) Prohibits an LM from being required to provide the information requested in this bill as a condition for license renewal, and from being subject to discipline for not providing the information requested.

6) Makes findings and declarations including, that in order to protect the privacy of licensees, while also gathering useful workforce data, it is necessary that some information collected from licensees only be released in aggregate form.

EXISTING LAW:

1) Establishes the Licensed Midwifery Practice Act of 1993, which provides for the regulation and licensure of licensed midwives (LMs) by the MBC. Specifies a person is qualified for licensure as an LM after either:

   a) Successful completion of a three-year postsecondary midwifery education program accredited by an MBC-approved organization, and successful completion of a comprehensive licensing examination equivalent to the exam given by the American College of Nurse Midwives; or,

   b) Successful completion of an educational program the MBC deems equivalent. [Business and Professions Code (BPC) § 2505 and § 2513]

2) 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 Workforce Education and Training Council within HCAI to coordinate California's health workforce education and training to meet the state's health care needs. [Health and Safety Code (HSC) § 128050 and § 128250]

3) Establishes the Midwifery Workforce Training Act, which requires HCAI, upon appropriation by the Legislature, to administer funding for a statewide study on midwifery education. Requires HCAI 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. [HSC § 128300(a) and § 128298(b)(1)]

4) Requires the MBC and other health care licensing boards to request workforce survey data at least biennially at the time of licensure or registration renewal for submission to HCAI for future workforce planning. Requires MBC or the Department of Consumer Affairs to provide the data to HCAI quarterly. Requires HCAI to maintain the confidentiality of the data collected and only release it in an aggregated format. [BPC § 502]

FISCAL EFFECT: According to the Senate Appropriations Committee, HCAI reports ongoing General Fund costs of approximately $195,000 for 1.0 Research Data Specialist to analyze additional health workforce data regarding LM eligibility and availability to serve as clinical preceptors and to submit findings to the Legislature. MBC notes minor and absorbable costs to update online applications, renewal instructions, BreEZe surveys, and other website and public newsletter content (Contingent Fund of the MBC).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, LMs are perinatal health professionals who provide maternity and newborn care, lactation support, and community-based services. Midwife preceptors are experienced providers who play a critical role in training, mentoring, and supervising aspiring LMs, bridging academic learning with hands-on clinical experience. The author notes that despite their importance, the current system does not support this training pathway. A shortage of preceptors, limited mechanisms to identify them, and demographic barriers often force trainees to complete their training out of state. While research shows strong outcomes for patients receiving midwifery care, a fragmented training pipeline creates structural barriers, particularly for rural and diverse communities. The author states that to address this gap, this bill allows LMs, at the time of licensure or renewal, to voluntarily complete a survey assessing their capacity to serve as preceptors. An expansion to this data collection is a critical step towards supporting the longevity of the practice and building a sustainable workforce that can meet California's maternal health needs."

2) **BACKGROUND**. Communities around California face a severe lack of access to reproductive health and maternity care. The California Hospital Association reports that from 2014 to 2024, more than 50 maternity units closed throughout the state. The maternity workforce shortage is one of several drivers, with a projected shortage of 1,100 OB/GYNs in California by 2030.

   a) **Maternal Health in California**. Like the rest of the nation, California is facing a maternal health crisis. Every five days, a Californian loses their life to pregnancy-related complications. According to the California Department of Public Health (DPH) pregnancy-related mortality dashboard, although the state's pregnancy-related mortality ratio is lower than the national ratio, it has been rising in recent years and the majority of these deaths are preventable. The severe maternal morbidity rate in California has also been rising and is higher than the national rate. Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that can result in significant short- or long-term health consequences. SMM has been steadily increasing in recent years. This crisis is disproportionately impacting Black, American Indian/Alaska Native, and Pacific Islander individuals.

      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.

   b) **Midwifery workforce**. California has two types of midwives: LMs and CNMs. LMs, regulated by the MBC, primarily practice in community-based settings, including birth

centers and homes. Nationally certified LMs are credentialed as certified professional midwives and are legally recognized in 38 states. CNMs are also registered nurses and are regulated by the California Board of Registered Nursing, primarily practicing in clinics and hospitals. CNMs are legally recognized in all 50 states. According to a 2024 California Health Care Foundation (CHCF) report on California's midwives, both LMs and CNMs provide high-quality care focused on pregnancy, childbirth, and postpartum, including family planning and newborn care, with CNMs also offering broader gynecologic services. There are about two CNMs for every LM in the state. According to a February 2025 CHCF Issue Brief (CHCF brief) there is a lack of racial and ethnic diversity in the workforce relative to the state. Only 12% of LMs and 10% of CNMs identified as Latino, while 45% of the state's population of women age 15 to 44 (considered reproductive age by the Centers for Disease Control and Prevention) was Latina. Two percent of LMs and 4% of CNMs identified as Black compared to 6% of women of reproductive age.

c) **LM training requirements**. Licensing requirements for LMs require a fingerprint-based background check, professional education, and an examination. There are three pathways to satisfying the education requirement of licensure as an LM in California, according to the MBC. One route includes training under a three-year postsecondary education program at an accredited midwifery school approved by the MBC (usually one accredited by the Midwifery Education and Accreditation Council). Upon completion of the educational requirements, which include 84 semester units of theoretical instruction and clinical experience evaluation, the candidate must pass a licensing examination administered by the North American Registry of Midwives (NARM). According to the MBC, there are seven programs in the nation that meet the criteria for approval, none of them located in California, although some programs offer distance learning options.

   A second option is for students to train in another state and apply for licensing from the MBC under reciprocity, an option only currently available to applicants licensed in Florida or Washington. These applicants must have a license verification sent to the MBC from the issuing state, showing a current, valid, and unrestricted license. The candidate must also provide an official certificate or diploma, transcript, and documentation of clinical training from the midwifery program, and evidence of a passing score on the NARM examination.

   Lastly, midwives may apply under a challenge mechanism that offers a student the opportunity to gain credit for previous midwifery education and clinical experience upon successful completion of the NARM examination. However, only one challenge mechanism program (the National Midwifery Institute in Vermont) is currently approved by the MBC. According to the MBC, as of April 1, 2026, there are 510 LMs licensed in the state, a 36% increase from 2017. The LM workforce has grown at a slow but steady pace over the past five years, with an average of 34 license applications received each year, 32 licenses granted, and 219 licenses renewed each year. So far in fiscal year 2025-26, 175 licenses were renewed and 16 new licenses issued. However, not all LMs are practicing; the CHCF brief found that in 2023, only 79% of LMs reported that they practiced midwifery.

d) **Clinical preceptorships**. An LM's clinical training is supervised by a preceptor, a licensed, actively practicing CNM, LM, or physician who trains students and evaluates

the student's performance as part of their educational requirements. Some programs adhere to the NARM registration standards for those eligible to act as preceptors, which also requires preceptors to have an additional three years of experience after credentialing or 50 primary or co-primary births beyond entry-level licensing requirements. Furthermore, a NARM-registered preceptor must have attended a minimum of ten out-of-hospital births and have attended a workshop, course, or module on cultural awareness within the last three years. In most MBC-approved training programs, a student is responsible for identifying their own clinical preceptor, in some cases prior to even applying to the program.

3) **SUPPORT**. The California Nurse-Midwives Association (CNMA) supports this bill and states that it will require the Medical Board of California to collect data on the capacity of LMs to serve as preceptors and train incoming students. This data will then be shared with HCAI to compile and submit a report to the Legislature. This bill is designed to strengthen the midwifery training pipeline and address a critical gap in California's maternity care workforce. CNMA concludes that this bill will support the longevity of the field, ensure the profession is reflective of the diverse communities they serve, and improve birth outcomes across California.

   Black Women for Wellness (BWW) supports this bill and states that California is currently facing a significant maternity care labor shortage, particularly in rural and underserved communities which has left us in a full maternal mortality crisis. Licensed midwives play a vital role in providing prenatal, birth, and postpartum care, as well as community-based services like lactation support. Studies have demonstrated how effective midwives are in reducing unnecessary intervention during labor, and in some cases saving lives. Midwife 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. BWW continues, that 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. BWW concludes that this bill 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.

4) **RELATED LEGISLATION**. AB 1696 (Stefani) would clarify 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. AB 1696 is pending a hearing in the Senate Health Committee.

5) PREVIOUS LEGISLATION.

a) SB 520 (Caballero), Chapter 601, Statutes of 2025, creates the California Nurse-Midwifery Education Fund in HCAI for the purpose of establishing California-based, master's level nurse-midwifery education programs, upon appropriation by the Legislature.

b) AB 836 (Stefani), Chapter 597, Statutes of 2025, requires HCAI, upon appropriation by the Legislature, to administer funding for a statewide study on midwifery education.

c) SB 65 (Skinner), Chapter 449, Statutes of 2021, established the California Momnibus Act, which, among other provisions, enacted the Midwifery Workforce Training Act to require HCAI to increase the number of students educated and trained as CNMs and LMs.

d) AB 1308 (Bonilla), Chapter 665, Statutes of 2013, established the Midwifery Practice Act, which specified the licensure and scope of practice requirements for LMs.

6) DOUBLE REFERRAL. This bill is double referred, it passed the Assembly Committee on Business and Professions with a 17-0 vote on June 16, 2026.

REGISTERED SUPPORT / OPPOSITION:

Support

Around-Birth Collective, Inc.
Black Women for Wellness
California Association of Licensed Midwives
California Nurse Midwives Association (CNMA)
California Women's Law Center
Hispanas Organized for Political Equality
March of Dimes
Medical Board of California
Strong Hearted Native Women's Coalition

Opposition

None on file

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