2026 NEBRASKA 407 CREDENTIALING REVIEW

Supplementary Report: Evidence and Criterion Evaluation for Scope of Practice Modernization of Nurse Midwifery

Submitted by: Nebraska Affiliate of the American College of Nurse-Midwives

Nebraska Revised Statute §71-407 et seq.

Component A	**Component B**
Full Practice Authority (FPA) through a structured transition-to-practice pathway, consistent with Nebraska's existing model for Nurse Practitioners.	Authorization to attend planned home birth, replacing Nebraska's categorical statutory prohibition with a regulated framework.

Executive Summary

What CNMs Are

- Graduate-educated, nationally board-certified Advanced Practice Registered Nurses (APRNs)
- Licensed by the Nebraska Department of Health and Human Services
- Provide evidence-based primary care, maternity care, newborn care, and women's health services across the lifespan
- Authorized in Nebraska by statute since **1984**

What Is Being Requested

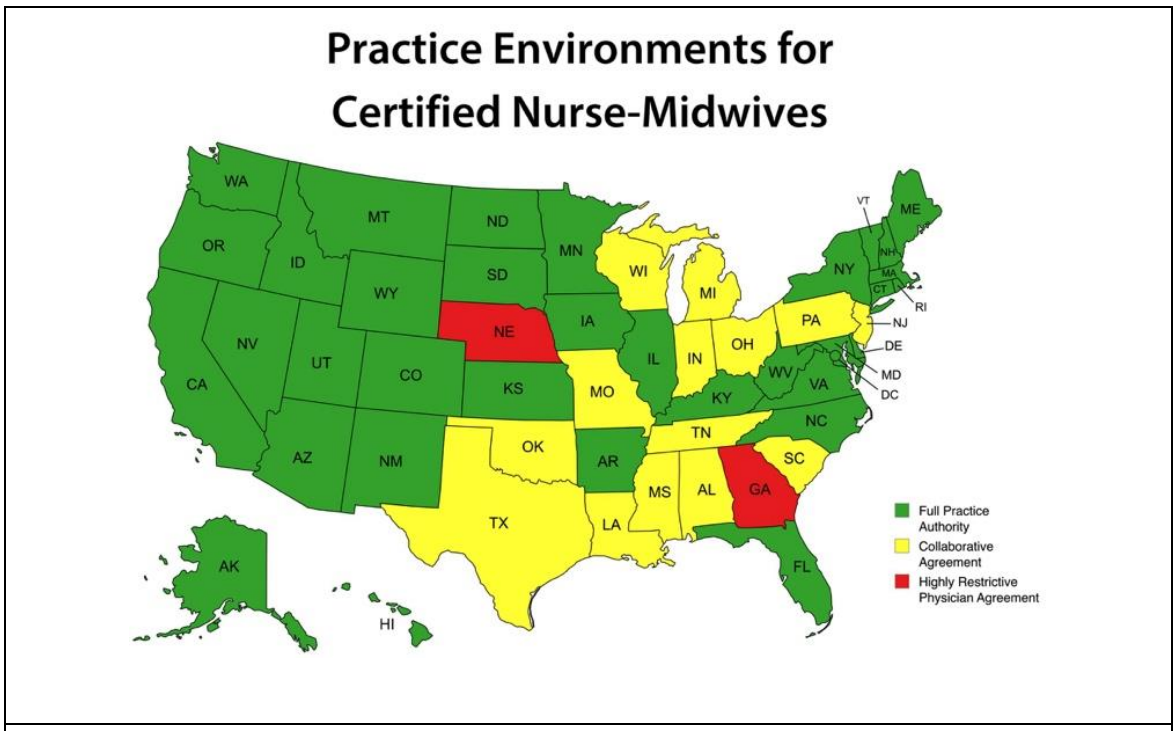
- **Component A:** Full Practice Authority (FPA) through a structured, phased transition-to-practice pathway, consistent with Nebraska's existing regulatory model for Nurse Practitioners
- **Component B:** Removal of Nebraska's categorical statutory prohibition on CNM-attended planned home birth, replaced with a regulated framework including eligibility and informed consent requirements

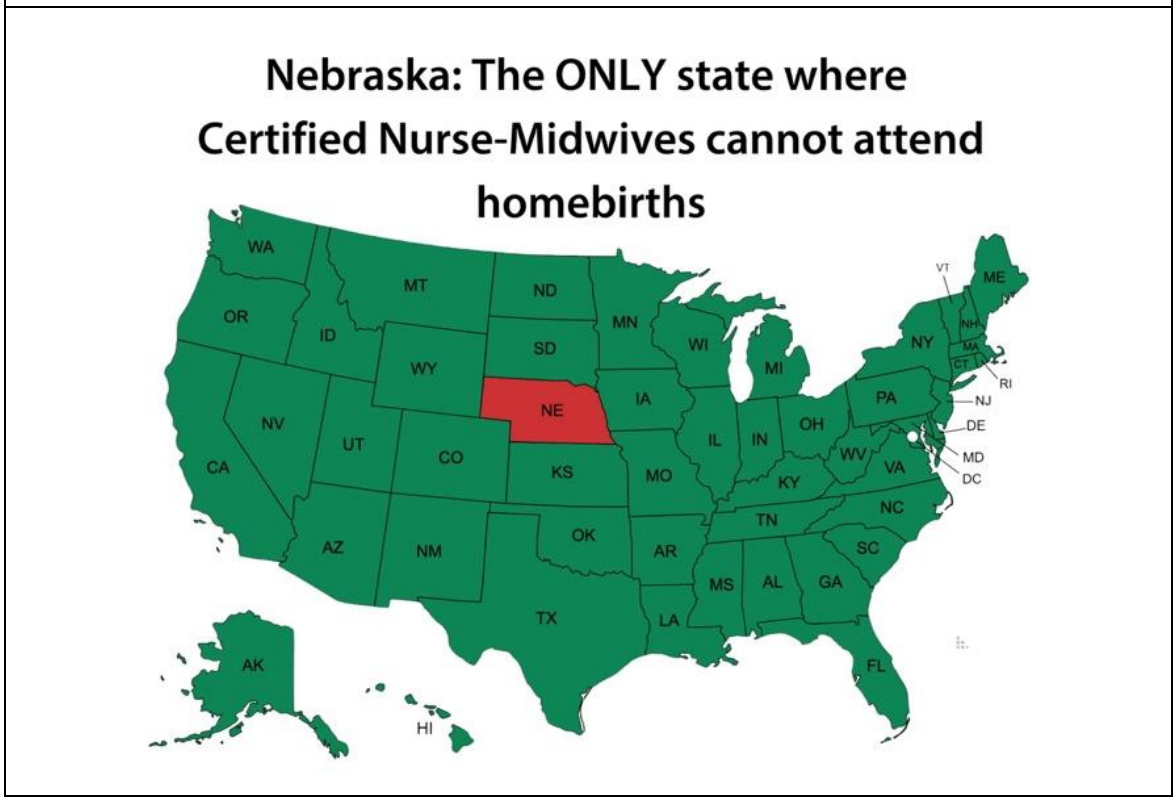
National Context: Where Nebraska Stands

- **34 states + DC** already grant FPA to CNMs, more than for any other Advanced Practice Provider group
- Nebraska granted FPA to CRNAs (**2002**) and NPs (**2015**); CNMs remain anomalously restricted despite equivalent education, certification, and licensure requirements
- Nebraska is **the only state** that has granted FPA to CRNAs and NPs without also granting it to CNMs (see appendix A)
- Nebraska is **the only state** with a categorical statutory prohibition on CNMs attending planned home births written into statute
- Nebraska is **one of two states** that require physician supervision language for CNMs in statute.

What These Reforms Are NOT

- Do not create a new profession
- Do not authorize unregulated practice
- Do not diminish state oversight or Board of Nursing authority
- Do not eliminate clinical obligations to consult, refer, or collaborate





Background

Nebraska's Maternity Care Crisis

- **51.6% of Nebraska counties** are maternity care deserts: no hospital, birth center, or obstetric providers of any kind[1][2]
- Nebraska ranks among the **five worst states** in the nation for maternity care access[1][2]
- Women in maternity care deserts face **13% increased risk of preterm birth** and higher rates of inadequate prenatal care[2][3]
- Women in Nebraska maternity care deserts travel an average of **34.4 miles** to reach maternity care, more than triple the distance compared to **10.5 miles in areas with full access** [5]
- Over 100 counties nationwide lost maternity care access since 2022; Nebraska's rural communities have not been spared[2][6]
- Obstetrician burnout, driven by on-call demands, liability exposure, and acuity, directly contributes to obstetric unit closures[7]

The CNM Solution

- CNMs attend births in rural hospitals at a rate **21% higher** in FPA states than in states requiring collaboration or supervision agreements[8]
- In rural maternity hospitals where CNMs practice: **86%** work alongside obstetricians; **44%** work with family physicians[8]
- FPA reduces **vicarious liability exposure for physicians**, removing a known deterrent to collaborative arrangements in rural areas[9]
- States with autonomous CNM practice have **more than twice as many CNMs per 1,000 births** (4.85 vs. 2.17)[21][22]
- Requiring physician oversight where **over half of counties have no obstetrician** is a structural barrier to care, not a safety measure
- Nebraska families are already choosing midwifery care at growing rates. CNM-attended births increased **31.6%** from 2017 to 2024 [4]
- In 2025, CNMs attended an estimated **2,613 births statewide** or approximately **11% of all Nebraska births** and **15% of all vaginal births** in the state; these figures may be undercounted by as much as 30% based on projections from practicing Nebraska CNMs [4]

History

- American Nurse-midwifery traces to the early **1910s**, one of the oldest advanced practice nursing roles in the U.S.[10]
- Frontier Nursing Service founded by Mary Breckinridge (**1925**), providing formal community-based maternity care and educational programing, four decades before the first NP program launched [10][11]
- American College of Nurse-Midwives (ACNM) began in **1929** and was incorporated in **1955**; national leadership in education, accreditation, regulation, and clinical standards[10]

Education & Credentialing

- Graduate-level (master's or doctoral) programs accredited by the Accreditation Commission for Midwifery Education (ACME)[12]
- Competency-based curricula covering: health assessment, pathophysiology, pharmacology, diagnosis, treatment planning, and management of normal and complex conditions

- Clinical training is substantial, with hourly requirements often exceeding other APRN pathways given the time dynamics of intrapartum care
- National certification via the American Midwifery Certification Board (AMCB); maintained through continuing education and periodic recertification
- The CNM education-to-licensure pathway which includes ACME-accredited graduate education, AMCB certification, and state licensure, fully aligns with the **NCSBN APRN Consensus Model** (Licensure, Accreditation, Certification, and Education; "LACE"), the nationally recognized framework for APRN regulatory standardization, ensuring that CNM practice authority rests on a consistent, evidence-based, and nationally validated credential structure[13]

Nebraska's Regulatory Framework

- Regulated under the Nebraska Nurse Practice Act and DHHS; subject to full Board of Nursing disciplinary authority
- Receive **among the lowest number of complaints** filed with the Nebraska Board of Nursing[14]
- Layered accountability: state licensure + national certification + continuing competency + institutional credentialing

Federal & National Policy Alignment

- The **Federal Trade Commission** has identified supervision requirements as anticompetitive "restraint of trade" with no well-founded safety justification[15]
- The **National Academy of Medicine** (Future of Nursing 2020–2030) called for scope-of-practice barriers to be permanently removed[16]
- The **American College of Obstetricians and Gynecologists (ACOG)** supports CNMs having full practice authority[17]

Criterion Evaluation

With this context established, the following criterion-by-criterion analysis demonstrates that the proposed reforms satisfy every standard set forth under Nebraska Revised Statute §71-407. The evidence supporting each criterion is substantial, peer-reviewed, and confirmed by the regulatory experience of 35 jurisdictions that have already made this change.

> **CRITERION 1**
> The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or current limitations.

Component A: Full Practice Authority

Nebraska's current requirement for physician supervision inadequately protects the public because it ties CNM practice authority to physician availability rather than to CNM education, certification, licensure, and demonstrated competence. In a state where more than half of counties lack maternity care access, a supervision requirement does not create meaningful clinical oversight; instead, it restricts where CNMs can practice, destabilizes patient access, and makes care dependent on private contractual arrangements rather than state-regulated professional competency. Decreasing access to qualified maternal care providers impacts the safety and welfare of Nebraska families.

- States with autonomous CNM practice have **4.85 CNMs per 1,000 births** vs. **2.17** in collaborative-agreement states[21][22]
- A public records review of 34 physician CNM supervision agreements in Nebraska found an average distance of **279 miles** between the supervising physician and the CNM; the signatory is frequently not the physician who would provide emergency care [25]
- A requirement that may not consistently ensure proximity, real-time availability, or direct involvement in emergency care cannot be justified as a public safety mechanism.
- Midwives are sometimes required to **pay physicians thousands of dollars annually**, sometimes located in other states, merely to maintain practice eligibility
- When a practice agreement is dissolved (for any reason), patients can immediately lose access to care; **competency-based licensure** is more stable and predictable for patients
- Nebraska has already recognized this principle for CRNAs and NPs; continued differential treatment of CNMs is not justified by evidence of greater clinical risk
- In restricted states, **50%** of all jurisdictions have below-average numbers of both obstetricians and midwives; in states with independent practice, only **16%** fall in that category. Supervision requirements do not expand the provider pool -- they limit both workforces together in communities that need them most. [24]

Therefore, the present scope limitation inadequately addresses public health, safety, and welfare because it restricts access to qualified maternity care clinicians -- particularly in rural and underserved communities -- without providing meaningful additional safety protection.

✓ Criterion 1, Component A SATISFIED

Component B: Home Birth Authority

Nebraska's categorical prohibition on CNM-attended planned home birth fails to protect the public because it does not prevent home births, it only prevents the most qualified birth attendants from being present at them. The prohibition is unenforceable in practice, unique among all 51 jurisdictions, and has produced a system in which families seeking home birth are legally compelled to access unregulated alternatives.

- Planned home births in Nebraska: **56 in 2015** → **119 in 2024** (**+112%**); rate rose from 2.18 to **5.00 per 1,000** live births (Nebraska Office of Vital Records)
- In total, **721 intended home births** were recorded in Nebraska from 2015–2024; the prohibition has not prevented them
- Nebraska's prohibition **does not prevent planned home birth**; it only prevents families from accessing CNMs, the most highly educated and rigorously regulated midwifery clinicians available
- Families denied CNM access may turn to attendants with **less clinical training, less regulatory accountability, with worse outcomes and higher rates of neonatal morbidity and mortality**
- Nebraska is **the only state** with this prohibition in statute; no other jurisdiction has found it necessary
- Nebraska has already demonstrated it considers CNM-attended home birth acceptable: when a Nebraska mother sued the State in 2026 to deliver at home with a CNM, the State settled the lawsuit by simply allowing it[29]

Nebraska Home Birth Data (2015–2024)[26]

Year	Total Births	Home Births	Intended Home Births	Rate per 1,000
2015	25,728	82	56	2.18
2016	25,656	91	59	2.30
2017	24,885	82	44	1.77
2018	24,538	79	58	2.36
2019	23,860	89	64	2.68
2020	23,419	105	81	3.46
2021	23,646	98	85	3.59
2022	23,385	82	68	2.91
2023	23,049	105	87	3.77
2024	23,780	154	119	5.00
TOTAL	241,946	967	721	2.98

Source: Nebraska Office of Vital Records, 2015–2024

Therefore, the current prohibition inadequately addresses public health and welfare because it eliminates the safest attendant option for families who choose home birth rather than preventing home birth itself.

✓ Criterion 1, Component B SATISFIED

CRITERION 2
Enactment of the proposed change would benefit the health, safety, or welfare of the public.

Component A: Full Practice Authority

Granting Full Practice Authority to Nebraska CNMs would produce direct, measurable benefits to public health. The evidence base is extensive, consistent across study designs and populations, and confirmed by the regulatory experience of 35 jurisdictions. CNM-led care consistently produces high-quality outcomes and is associated with improvements across several clinically meaningful measures

Clinical Outcomes Evidence

- Cochrane Review, 15 RCTs, 17,674+ women: midwife-led continuity care associated with:[18]
  - **Fewer preterm births** (RR 0.76)
  - **Fewer instrumental vaginal births** (RR 0.90)
  - **More spontaneous vaginal births** (RR 1.05)
  - **Lower combined fetal loss and neonatal death** (RR 0.84)
  - No adverse effects in any trial
- Meta-analysis of **~1.4 million pregnancies**: lower risks across most neonatal morbidity measures; no significant difference in intrapartum or neonatal mortality[20]
- U.S. Military Health System (136,848 births): CNM-attended births had **6.7% cesarean rate** vs. **31.9%** for physician-attended, plus lower induction, postpartum hemorrhage, and preterm birth rates [27]

- Milbank Quarterly scoping review (66 U.S. studies): CNM care consistently associated with **improved patient satisfaction and lower intervention rates** across all six IOM quality domains[19]
- A validated measure of how well midwives are integrated into a state's health care system -- including whether they can practice independently, receive Medicaid reimbursement, and admit patients to hospitals -- found that states with stronger midwifery integration had significantly lower rates of cesarean birth, preterm birth, low birth weight, and neonatal death. **Nearly 12% of the variation in neonatal death rates across states** is explained by how integrated midwifery practice is in that state[28]

Workforce Access Impact

- Written practice agreements prevent expansion of the midwifery workforce by requiring growth of the obstetrician workforce first. In a state with a severe obstetrician shortage, the only group this policy harms are patients.
- FPA states: **4.85 CNMs per 1,000 births** vs. 2.17 in collaborative-agreement states[21]
- **34%** of rural hospitals in FPA states have CNMs attending births vs. **28%** in collaborative-agreement states[21]
- Midwives are present in **46.3%** of counties in independent practice states vs. **39.2%** in restricted states ($p<.001$); the gap is most pronounced in rural counties. [24]
- Independent states have midwives in a higher proportion of counties across all nine Rural-Urban Continuum Code categories, including completely rural counties where access barriers are most severe [24]
- Nebraska's NP FPA experience: substantial growth in rural NP practice following reform; same benefit expected for CNMs[30]
- States with independent midwifery practice experience faster midwifery workforce growth than states maintaining written practice agreement requirements, a sustained divergence confirming that **regulatory structure, not population need, limits workforce supply** [23]
- States that simultaneously adopt all three enabling policies, **independent licensure, full Medicaid reimbursement parity, and independent hospital admitting privileges**, have both a larger midwifery workforce and a faster rate of workforce growth than states that adopt fewer or none; Nebraska currently lacks all three for CNMs[24]

Therefore, granting FPA would benefit public health, safety, and welfare by expanding the CNM workforce, improving access in rural and underserved communities, and delivering care consistently associated with better outcomes and lower intervention rates across a robust and peer-reviewed evidence base.

✓ Criterion 2, Component A SATISFIED

Component B: Home Birth Authority

Authorizing CNM-attended planned home birth within a regulated framework would produce direct public health benefits by replacing an unregulated practice environment with a structured, accountable one. The benefit is not hypothetical since home births are already occurring in Nebraska. The question is not whether they will continue, but whether they occur with or without the most qualified, regulated clinician available.

- Specific low risk criteria have been delineated in the proposal based on feedback from physician, hospital and other stakeholders.
- CNM involvement provides **evidence-based patient selection**: women who should not deliver at home are counseled and referred by the most qualified clinician available
- CNMs are trained to recognize evolving complications (hemorrhage, abnormal fetal heart rate, failure to progress) and initiate **timely consultation and transfer**

- CNMs can **follow the patient to the hospital** and continue care there, with no conflict of interest regarding setting, unlike home-only attendants.
- CNM continuity across prenatal, intrapartum, and postpartum care produces a **richer clinical information base** and deeper patient-provider trust at the most critical moment
- Because CNMs are licensed practitioners, **full state regulatory accountability applies** to all aspects of their practice, a protection that does not apply to unregulated attendants
- A growing practice area warrants stronger oversight, not continued exclusion from the licensed healthcare system

Therefore, authorization of CNM-attended home birth within the proposed framework would benefit public health, safety, and welfare by creating structured clinical safeguards where none currently exist, improving patient selection, and ensuring regulatory accountability applies to an already-occurring practice.

✓ Criterion 2, Component B SATISFIED

CRITERION 3
The proposed change does not create a significant new danger to the public.

Component A: Full Practice Authority

Full Practice Authority does not introduce new clinical tasks, new patient populations, or new practice settings. It removes the administrative requirement of a physician supervision agreement that is not linked to clinical competency or patient safety outcomes. The evidence from 35 jurisdictions that have made this change confirms that FPA is associated with no increase in harm and, in several outcome domains, with measurable improvement.

- The reform **modifies administrative structure only**; it does not alter clinical competencies, professional standards, or accountability mechanisms
- Clinical consultation and interdisciplinary collaboration continue to be required by **good clinical practice**, not just by statute
- Autonomous-practice states had significantly **lower odds of cesarean (AOR 0.87), preterm birth (AOR 0.87), and low birth weight (AOR 0.89)**, the opposite of increased harm [21]
- No state that has granted CNM FPA has **subsequently reversed** that decision; 35 jurisdictions of consistent regulatory experience (more than for any other APRN group).
- Nebraska Board of Nursing data: CNMs are **among the least frequently disciplined** licensed providers in the state[14]
- The **structured transition-to-practice pathway** provides an additional layer of protection: early-career CNMs practice under mentorship before applying for independent authority
- Independent practice states are **more likely to have above-average density of both midwives and obstetricians** (43% vs. 19% in restricted states) and less likely to have below-average density of both (16% vs. 50%)[24]; CNM FPA is associated with healthcare environments supportive of all reproductive healthcare providers, not with workforce displacement

Therefore, the proposed change does not create a significant new danger to the public. The outcomes data from 35 jurisdictions, Nebraska's own disciplinary record for CNMs, and the structured transition-to-practice pathway all support this conclusion.

✓ Criterion 3, Component A SATISFIED

Component B: Home Birth Authority

The danger analysis for Component B must be framed against the correct baseline. The choice Nebraska faces is not between CNM-attended home birth and no home birth. It is between CNM-attended home birth and unregulated home birth, which is already occurring at an increasing rate. Evaluated against that baseline, the proposed framework reduces risk rather than creating it.

- The correct comparator is not **"CNMs vs. no home birth"**; it is **"CNMs vs. unregulated attendants"**
- The proposed framework creates **structured clinical safeguards** where none currently exist: eligibility criteria, informed consent, and provider standards.
- Eligibility criteria limit CNM home birth attendance to genuinely **low-risk, appropriately screened** individuals
- These are the same evidence-based practices applied in regulated home birth practice across the **large majority of U.S. states** that authorize it
- Evaluated against the correct comparator (current unregulated practice), the framework **reduces rather than increases risk**

Therefore, the proposed framework does not create a significant new danger. It creates structured safeguards in a practice environment that currently has none, replacing the most dangerous possible configuration -- unregulated attendants, no eligibility criteria, no required transfer protocols -- with a licensed, accountable clinical framework.

✓ Criterion 3, Component B SATISFIED

CRITERION 4

Current education and training adequately prepare practitioners to perform the new skill or service.

Component A: Full Practice Authority

CNMs are not seeking authority to perform tasks outside their training. Every clinical function encompassed by Full Practice Authority is already included in accredited CNM graduate education and assessed through national certification. The regulatory change being requested brings Nebraska law into alignment with CNM education, it does not expand what CNMs are trained to do.

- This is **not an expansion into unfamiliar tasks**; it is regulatory modernization authorizing CNMs to perform tasks they are already trained to do
- CNM graduate programs provide comprehensive preparation in:
  - Advanced physical assessment and clinical reasoning
  - Pharmacology and prescriptive authority management
  - Pathophysiology and differential diagnosis within CNM scope
  - Management of prenatal, intrapartum, postpartum, and interconceptional conditions
  - Recognition and management of complications requiring consultation or transfer
  - Leadership, professional practice management, and systems-based practice
- All competencies assessed through **national certification** and maintained through continuing education[12]

Therefore, current CNM education and training fully and adequately prepare practitioners for Full Practice Authority. No new training, curriculum change, or additional certification is required.

✓ Criterion 4, Component A SATISFIED

Component B: Home Birth Authority

CNM education explicitly encompasses out-of-hospital birth competencies. These are not incidental skills, they are core components of midwifery education that reflect the historical and contemporary scope of CNM practice nationally. The home birth setting does not require new clinical knowledge; it requires the application of existing competencies within a specific logistical context.

- CNM programs provide direct preparation for planned out-of-hospital birth competencies:
  - Physiologic labor support and management of normal birth process
  - Risk stratification and ongoing intrapartum assessment
  - Recognition of obstetric emergencies: hemorrhage, cord prolapse, shoulder dystocia, neonatal compromise
  - Newborn transition assessment and **neonatal resuscitation**
  - Postpartum maternal and newborn evaluation
  - Consultation and transfer decision-making
- Core competencies are **not setting-specific**; the home birth context adds logistical considerations addressed by site-specific readiness requirements and transfer protocols

Therefore, current CNM education and training adequately prepare practitioners for planned out-of-hospital birth attendance. The competencies required are already embedded in every accredited CNM graduate program.

✓ Criterion 4, Component B SATISFIED

CRITERION 5

Appropriate post-professional programs and competence assessment measures are available.

Component A and B: Full Practice Authority and Home Birth Authority

Nebraska does not need to build new infrastructure to support these reforms. The regulatory mechanisms, institutional relationships, and professional frameworks required already exist. They are the same structures that currently govern NP transition-to-practice authority in the state. The proposed pathway applies a proven model to CNMs.

- Nebraska already possesses the institutional and regulatory infrastructure needed; the framework is modeled on existing APRN transition mechanisms
- Proposed transition-to-practice pathway components:
  - Defined experience thresholds (clinical hours) before applying for FPA
  - Formal transition agreement with a qualified supervising/mentoring clinician
  - Board-administered application and review process
  - Post-independence obligations to consult and refer when clinically indicated
- Qualified mentors, including both CNMs and collaborating physicians, are available to support the pathway
- Ongoing competence is reinforced through:
  - AMCB Certification Maintenance Program (continuing competency requirements)
  - Nebraska monitoring and licensing continuing education requirements
  - Employer-based credentialing, privileging, and peer review
  - Emergency skills maintenance (e.g., neonatal resuscitation, BLS, ACLS)
  - Case review and quality assurance processes in hospital and clinical settings

Therefore, appropriate post-professional programs and competence assessment measures are available and ready to support both Component A and Component B. Nebraska's existing regulatory infrastructure is sufficient; no new programs, boards, or oversight mechanisms are required.

✓ Criterion 5, Component A and B SATISFIED

CRITERION 6

Adequate measures exist to assess competence and take action if practitioners are not competent.

Component A: Full Practice Authority

Nebraska's existing regulatory framework provides robust, multilayered mechanisms for assessing CNM competence and taking action when practitioners are not performing adequately. None of these mechanisms depend on the existence of a physician supervision agreement, and none would be diminished by its removal. Full Practice Authority changes the administrative structure of CNM practice but does not alter the accountability framework.

- Nebraska's existing regulatory infrastructure provides robust, fully adequate mechanisms; **none are altered or diminished** by this proposal
- Existing accountability mechanisms:
  - Initial licensure: degree verification, national certification, and clinical preparation review
  - Periodic licensure renewal with continuing competency requirements
  - Board complaint investigation and adjudication: reprimand, probation, suspension, revocation
  - Mandatory reporting obligations for employers and institutions
  - Hospital credentialing: peer review, privileging, and ongoing professional practice evaluation
  - National Practitioner Data Bank reporting for eligible adverse actions
- The Board retains **full authority to investigate, sanction, and protect the public** regardless of whether a CNM practices independently or under a collaborative agreement

Therefore, adequate measures exist to assess CNM competence and take action if practitioners are not performing competently. These mechanisms are already in place, already functioning, and already applicable to CNMs regardless of their practice authority status.

✓ Criterion 6, Component A SATISFIED

Component B: Home Birth Authority

The Board of Nursing's disciplinary authority over CNMs is not limited by practice setting. A CNM who attends a home birth is subject to the same licensure requirements, complaint investigation processes, and disciplinary sanctions as a CNM practicing in a hospital. Authorizing out-of-hospital practice does not create a regulatory gap, it brings an existing practice context within a clearer statutory framework.

- CNMs are licensed practitioners; **the Board's full disciplinary authority applies to all aspects of their practice**, including care provided in out-of-hospital settings
- Practice in a patient's home does not diminish state regulatory authority; it operates within it
- This statutory change would also clarify, under Nebraska's Uniform Credentialing Act, that attending a planned birth as a midwifery provider is a credentialed activity requiring a valid

professional license, bringing greater clarity to a statutory gap that currently creates uncertainty for both families and providers

- The risk stratification, documentation, and reporting requirements in the proposed language give the Board a **richer information basis** for monitoring and taking action

Therefore, adequate measures exist to assess competence and take action for Component B as well. CNM licensure already provides full Board authority over out-of-hospital practice, and the proposed framework adds eligibility and documentation requirements that strengthen, rather than reduce, the Board's oversight capacity. These mechanisms function independently of supervision agreements and remain fully enforceable under an independent practice model.

✓ Criterion 6, Component B SATISFIED

Conclusion

Nebraska has already set the precedent, granting FPA to CRNAs (2002) and Nurse Practitioners (2015) because the evidence supported it. The evidence supporting CNM-led care is equally robust. These reforms are the logical, evidence-aligned next steps.

Summary of findings

- All 6 statutory criteria are **satisfied** for both Component A (FPA) and Component B (Home Birth Authorization)
- **Component A (FPA):** Expands access, improves workforce deployment, strengthens care continuity, particularly in rural and underserved communities
- **Component B (Home Birth):** Replaces exclusion with oversight; improves safety in an existing practice context that the prohibition does not prevent
- These reforms will **align Nebraska with the overwhelming majority of states**, maintain rigorous Board of Nursing accountability, and deliver measurable benefits to Nebraska families

The Nebraska Affiliate of the American College of Nurse-Midwives respectfully requests approval of the proposed scope of practice expansions for Certified Nurse-Midwives as described in Parts A and B of this application, submitted pursuant to Nebraska Revised Statute §71-407 et seq.

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Appendix A: Full Practice Authority Comparison by State

State	CNM	NP	CRNA (opt out)
Alabama	No	No	No
Alaska	Yes	Yes	Yes
Arizona	Yes	Yes	Yes
Arkansas	Yes	No	Yes
California	Yes*	No	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes	Yes	No°
Delaware	Yes	Yes	Yes
Florida	Yes*	No	No
Georgia	No	No	No
Hawaii	Yes	Yes	No°
Idaho	Yes	Yes	Yes
Illinois	No	No	No°
Indiana	Yes	No	No
Iowa	Yes	Yes	Yes
Kansas	Yes	Yes	Yes
Kentucky	Yes*	No	Yes
Louisiana	No	No	No
Maine	Yes	Yes	No°
Maryland	Yes	Yes	No°
Massachusetts	Yes	Yes	Yes
Michigan	No	No	Yes
Minnesota	Yes	Yes	Yes
Mississippi	No	No	No
Missouri	No	No	No
Montana	Yes	Yes	Yes
Nebraska	**No**	**Yes**	**Yes**
Nevada	Yes	Yes	No
New Hampshire	Yes	Yes	Yes
New Jersey	No	No	No
New Mexico	Yes	Yes	Yes
New York	Yes	Yes	No
North Carolina	Yes*	No	No

State	CNM	NP	CRNA (opt out)
North Dakota	Yes	Yes	Yes
Ohio	No	No	No°
Oklahoma	No	No	Yes
Oregon	Yes	Yes	Yes
Pennsylvania	No	No	No
Rhode Island	Yes	Yes	No°
South Carolina	No	No	No
South Dakota	Yes	Yes	Yes
Tennessee	No	No	No°
Texas	No	No	No
Utah	Yes	Yes	Yes
Vermont	Yes	Yes	No°
Virginia	Yes	No	No
Washington	Yes	Yes	Yes
West Virginia	Yes	No	No°
Wisconsin⁺	No	No	Yes
Wyoming	Yes	Yes	Yes
District of Columbia	Yes	Yes	No°
TOTALS (51 jurisdictions)	**35 Yes / 16 No**	**28 Yes / 23 No**	**25 Yes / 26 No**

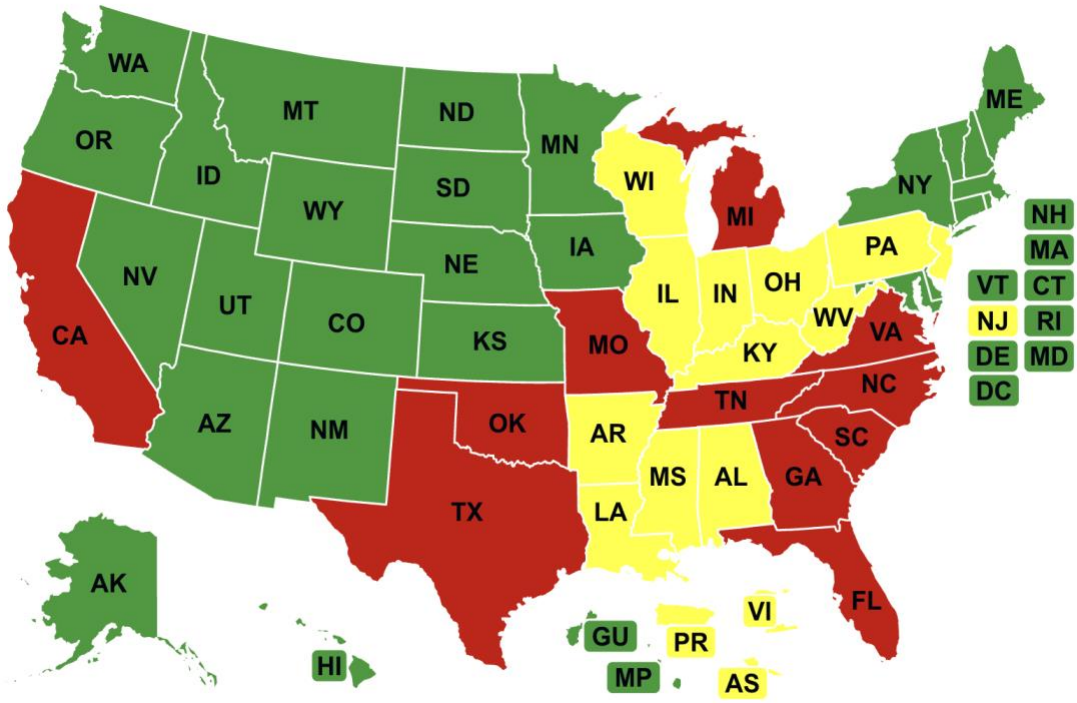
Note. Yes = Full Practice Authority (or independent practice authorized under state law with no physician supervision or collaboration requirements) **Yes*** = Pathway to Full Practice Authority for CNMs (transition-to-practice requirement before independent practice (n = 4) **No** = Collaborative or supervisory agreement with physician required. **No°=** indicates that the state has not opted out of CMS physician supervision requirements for CRNAs; however, state statute permits autonomous CRNA practice either independently or under nonrestrictive collaborative language. Estimates of CRNA independent practice vary widely depending on whether one refers to federal CMS supervision rules (25 states) or state statutory language**.**

Nebraska (bold) is the only jurisdiction in the nation that grants Full Practice Authority to both NPs and CRNAs while continuing to require a supervising physician for CNMs.

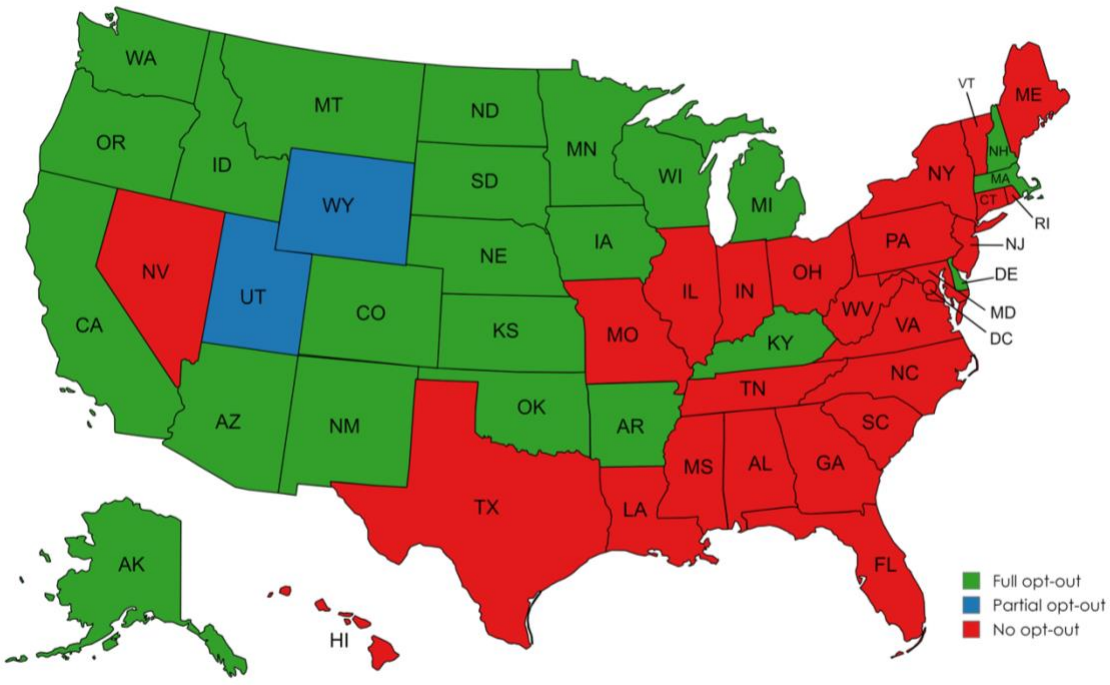
Sources: *American Association of Nurse Practitioners, State Practice Environment (January 2026); American College of Nurse-Midwives, Practice Environment for Certified Nurse-Midwives (March 2026); AANA, Practice in your state (May 2026).*

+Wisconsin passed FPA for CNMs and NPs to be enacted in late 2026

Disclaimer: *This table was compiled by the Nebraska Affiliate of the American College of Nurse-Midwives for the purpose of this 407 Credentialing Review using the sources cited above. It is provided for comparative context only, was prepared by the applicant group, and could contain errors. Laws change and interpretations vary; readers should verify individual state classifications against each state's nurse practice act and board of nursing regulations before relying on any entry.*



Nurse Practitioner State Practice Environment,
accessed from American Association of Nurse Practitioners 5/8/2026
Green= Full practice, Yellow= reduced practice, Red= Restricted Practice



CRNA Opt-out states,
Accessed from American Association of Nurse Anesthetists, 5/8/2026
Green=Full opt out from CMS supervision requirements, Blue= partial opt-out, Red=No opt-out