

NEBRASKA 407 CREDENTIALING REVIEW

Modernizing the Certified Nurse Midwifery Practice Act

Aligning Nebraska's regulation of certified nurse-midwives with their education, national certification, and the standards already applied to other advanced practice registered nurses.

Presented to the 407 Technical Review Committee

Presented by Elizabeth Mollard, PhD, CNM, WHNP, IBCLC on behalf of
Nebraska Certified Nurse-Midwives (applicant group)

Why are we asking for a change?

1

Nebraska has a maternity care access problem

More than half of Nebraska counties have no maternity provider of any kind.

2

Nebraska already licenses a workforce it is not using

113 certified nurse-midwives hold active licenses. Roughly 44 attend births.

3

The limits on that workforce are regulatory, not clinical

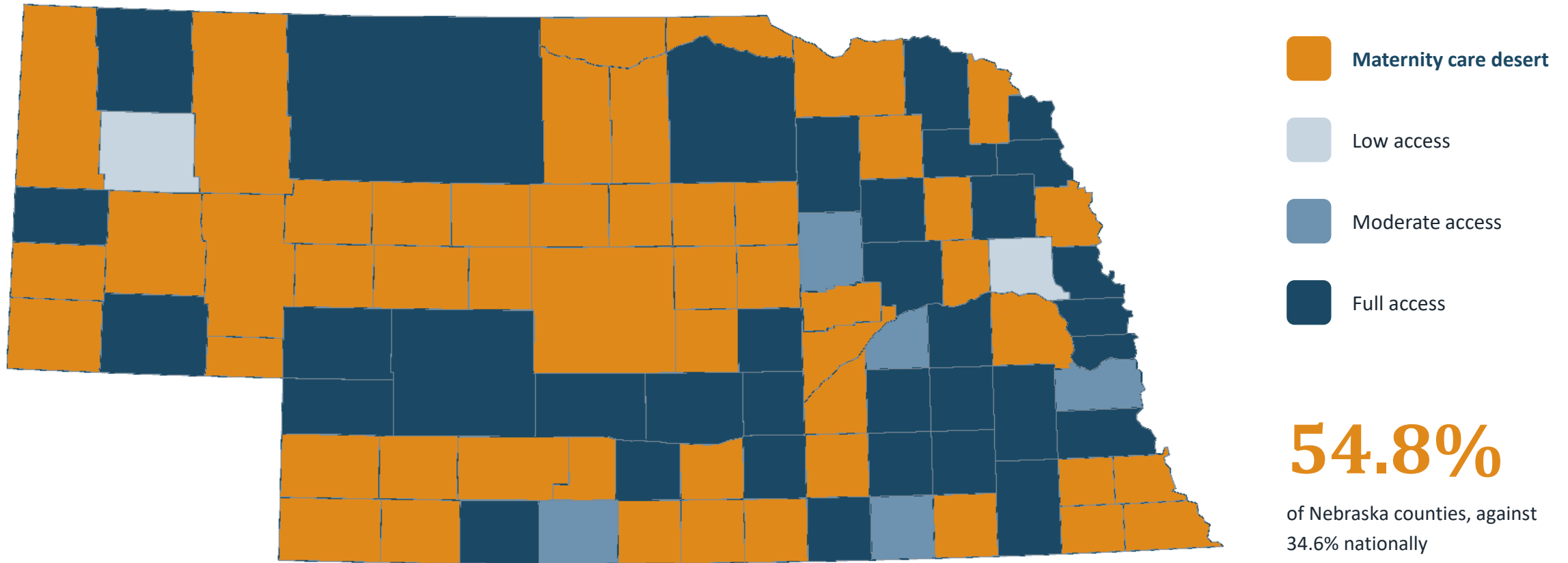
They can be removed while strengthening the state's ability to set standards and hold clinicians accountable.

The ask: that this committee recommend approval of the proposed amendments to the Certified Nurse Midwifery Practice Act.

THE PROBLEM

Most of Nebraska is a maternity care desert

Access to maternity care by county. The amber counties have no hospital offering obstetric care, no birth center, and no obstetric provider of any kind.



Source: March of Dimes, Maternity Care Desert: Nebraska, 2026 Report. Colors adapted from the original for legibility; categories unchanged.

THE PROBLEM

Nebraska trails the country on maternity care

Four measures on which the state ranks poorly against national comparisons.

54.8%

of Nebraska counties are
maternity care deserts

34.6% nationally

40th

rank for preterm birth rate

of 52 states and territories

25.1

maternal deaths per
100,000 births

18.6 nationally

51st

rank for midwifery
integration

of 51 — last in the country

Read together: Nebraska is not short of maternity need. It is short of maternity clinicians, and of ways to deploy the ones it has.

1 March of Dimes maternity care desert data and PeriStats, Nebraska, 2026. 2 March of Dimes 2025 Report Card for Nebraska; preterm rate 11.1% (NCHS 2024).

3 March of Dimes PeriStats; U.S. rate from NCHS 2023. 4 Birth Place Lab, Midwifery Integration Scoring System, 2024. Nebraska 23 of 100; national average 51.

Certified Nurse-Midwives Are Part of the Existing Workforce

CNMs are advanced practice registered nurses (APRNs)

CNMs complete graduate-level midwifery education

CNMs have been a licensed profession in Nebraska since 1984 (42 years)

CNMs are nationally certified through AMCB

CNMs provide prenatal, birth, postpartum, newborn, gynecologic, and primary care

CNMs already practice in hospitals, clinics, rural communities, and health systems

The demand for midwifery care is increasing in Nebraska

~2,613

births attended by certified nurse-midwives
statewide in 2025

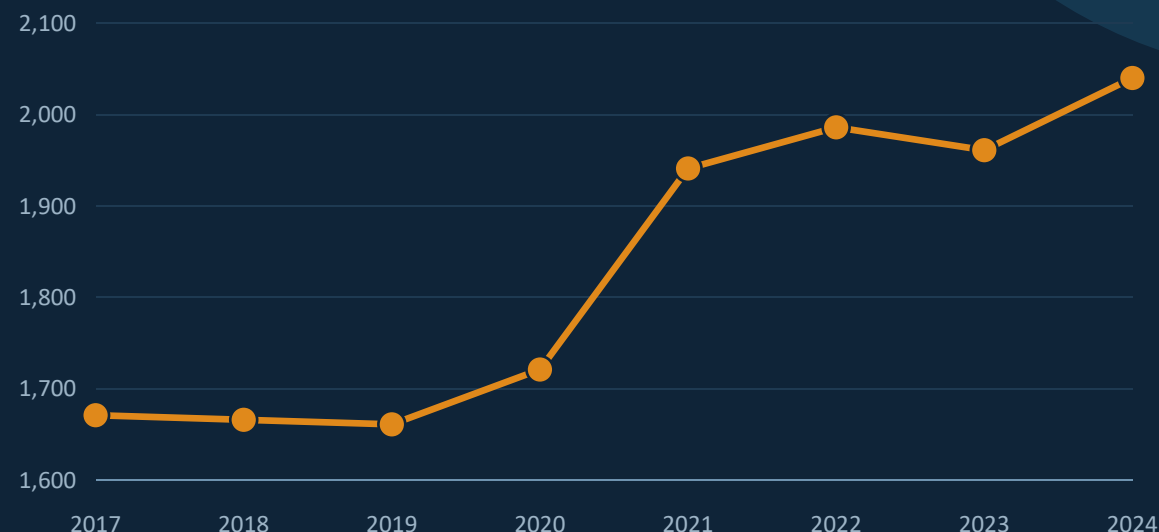
Estimated at about 11% of all Nebraska births and 15% of vaginal
births.

Roughly one in nine Nebraska babies.



CNM-ATTENDED BIRTHS, 2017–2024

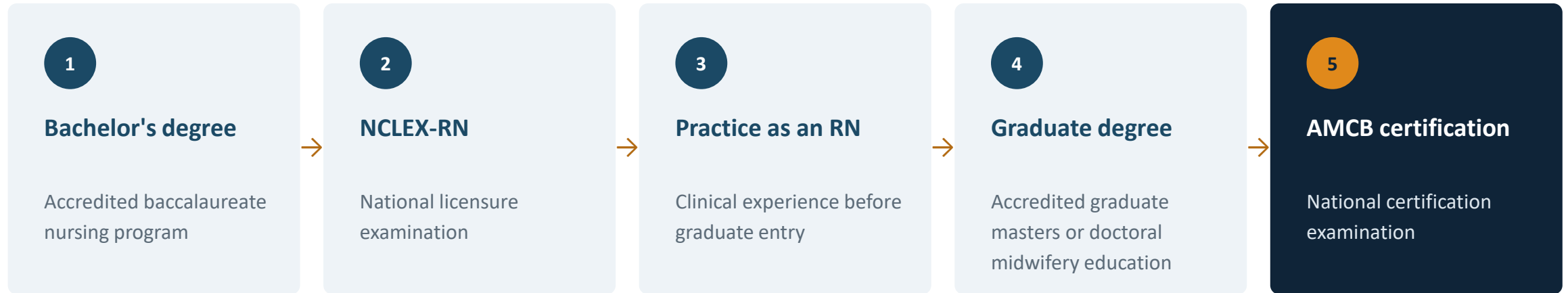
1,670 in 2017 → 2,039 in 2024



Nebraska is not being asked to build a market for midwifery care. It is being asked to stop limiting one that already exists.

What a certified nurse-midwife is

Every CNM licensed in Nebraska has completed the same five-stage pathway.



Registered nurse experience before midwifery practice

8.3 years mean **7 years** median

Roughly **17,000** hours of nursing practice before entering midwifery.

Already in the Nebraska system

CNMs are advanced practice registered nurses. They already practice in Nebraska hospitals, clinics, rural communities, and health systems, under Board licensure and discipline.

This is not a new profession the state would be creating. It is an existing, regulated one the state already licenses.

Nurse-midwife led care improves outcomes

Across randomized trials and U.S. state-level data, the findings point the same way.

Fewer cesarean births

Fewer instrumental
births

More spontaneous
vaginal birth

Better prenatal care
engagement

Fewer preterm births

Lower rates of low birth
weight

Higher breastfeeding
rates

Better reported
experience of care

Sandall J, Fernandez Turienzo C, Devane D, et al. Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2024;4:CD004667. · Vedam S, Stoll K, MacDorman M, et al. Mapping integration of midwives across the United States. PLoS One. 2018;13(2):e0192523. · American College of Nurse-Midwives. Core Competencies for Basic Midwifery Practice, 2025. · Full citations and the underlying workforce and outcome analyses are set out in the Supplemental Evidence Report and Criterion Evaluation submitted with this application.

Nurse-midwives are more than just birth providers

ACNM Core Competencies for Basic Midwifery Practice, updated 2025.

Five sections of the framework

Hallmarks of midwifery

Professional responsibilities

Midwifery management process

Fundamentals of practice

Clinical care across the lifespan

Clinical care across the lifespan

Primary care

Preconception

Gynecologic

Prenatal

Intrapartum

Postpartum

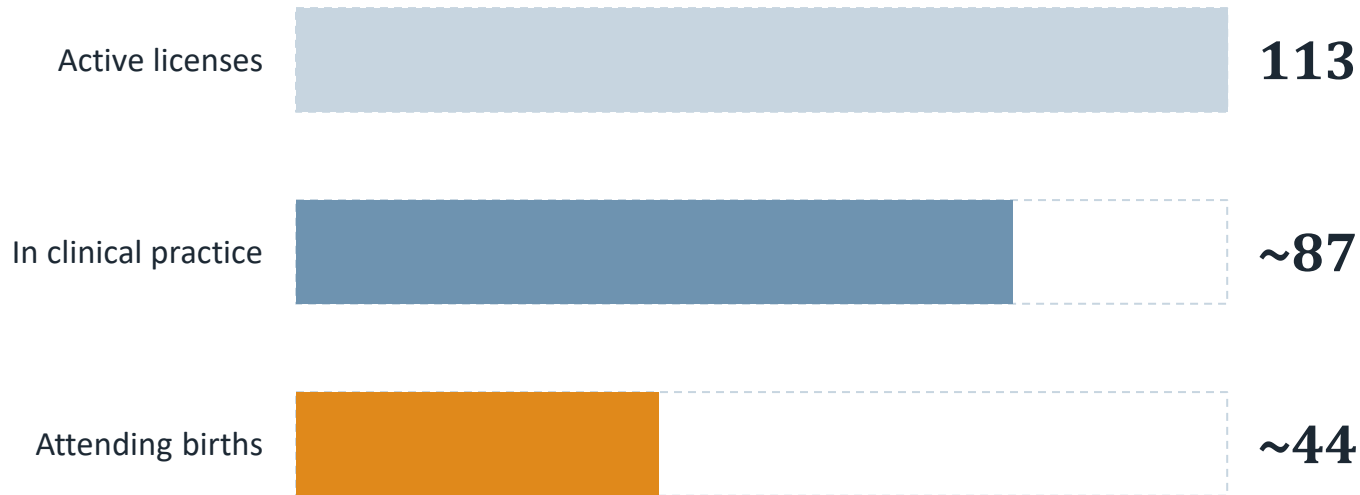
Newborn

Menopause

Consultation, collaboration, and referral are built into every domain.

Nebraska has nurse-midwives it is not using

Where the licensed nurse-midwife workforce actually goes.



Dashed outline shows the full licensed pool of 113.

Share of licensed Nebraska CNMs attending births

39%

Six in ten licensed nurse-midwives are not attending births — in a state where more than half of all counties have no maternity provider at all.

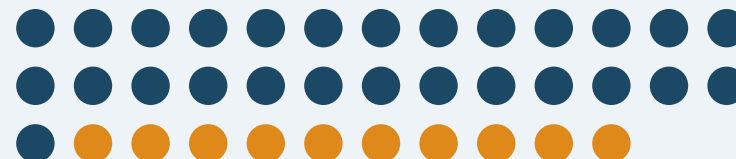
The point: Nebraska has a maternity provider shortage yet Nurse-Midwives unable to work due to our laws

And the ones attending births are in ten communities

Nebraska cities with a certified nurse-midwife providing birth care.



73% of communities with a birthing facility have no practicing CNM



37 Nebraska communities have a birthing facility, 44 facilities in all.

Only 10 have a practicing CNM.

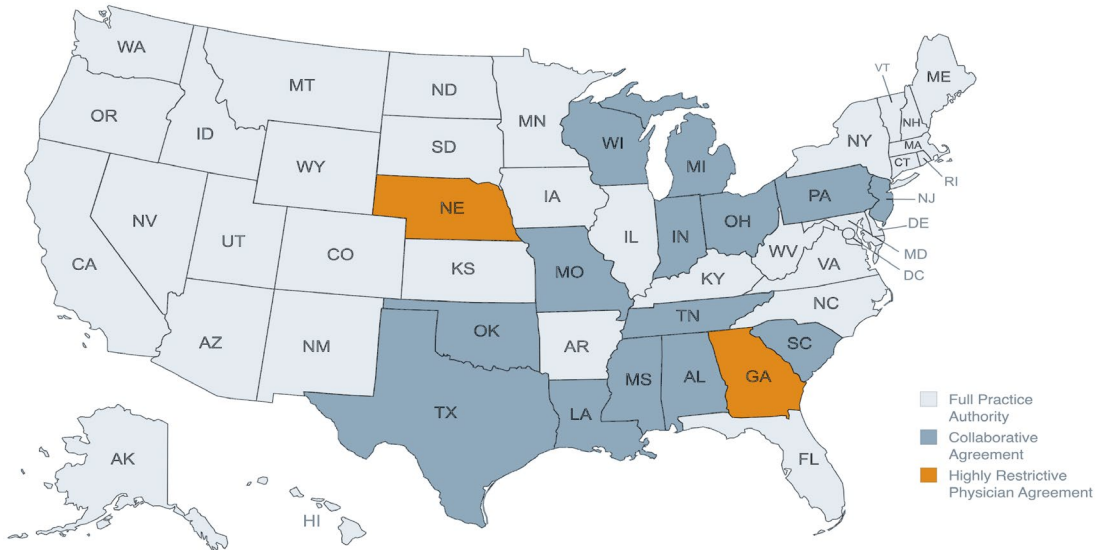
Nebraska Perinatal Quality Improvement Collaborative, identifying 44 birthing facilities in 37 communities. CNM practice locations compiled by the author, current as of September 2026.

THE MISMATCH

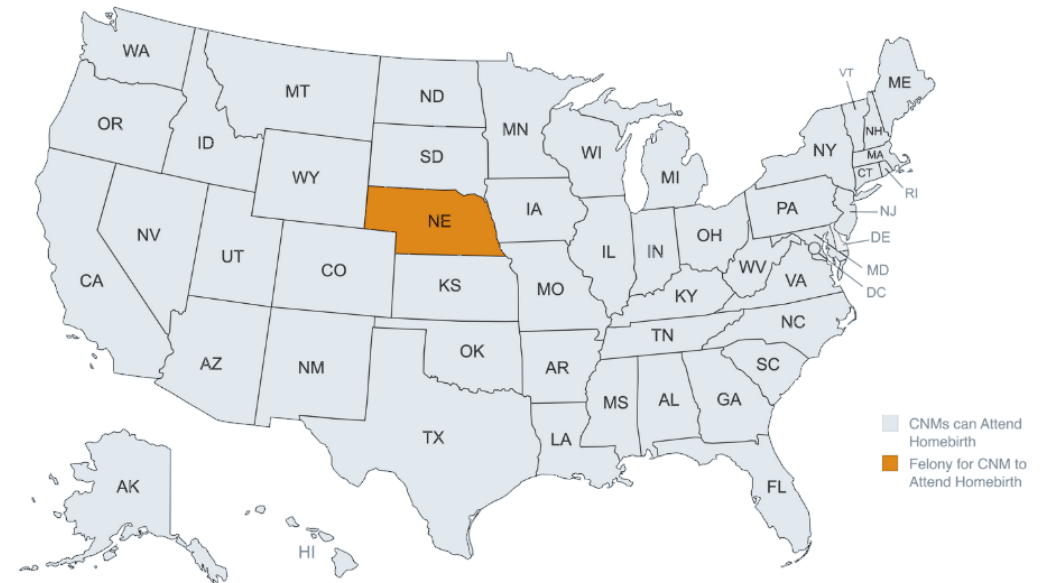
Nebraska is a national outlier twice over

Practice environment and permitted settings, compared across the states.

PRACTICE ENVIRONMENT



PLANNED HOME BIRTH



Two maps, one state: Nebraska is in the most restrictive category on both. On the second map the ONLY state with a categorical statutory prohibition on nurse-midwife-attended planned home birth.

What the practice agreement looks like in real life

279 mi

average distance between the certified nurse-midwife and the collaborating physician

Across the physician–CNM agreements obtained and reviewed under a public records request.

AND CNMS PAY FOR THEM

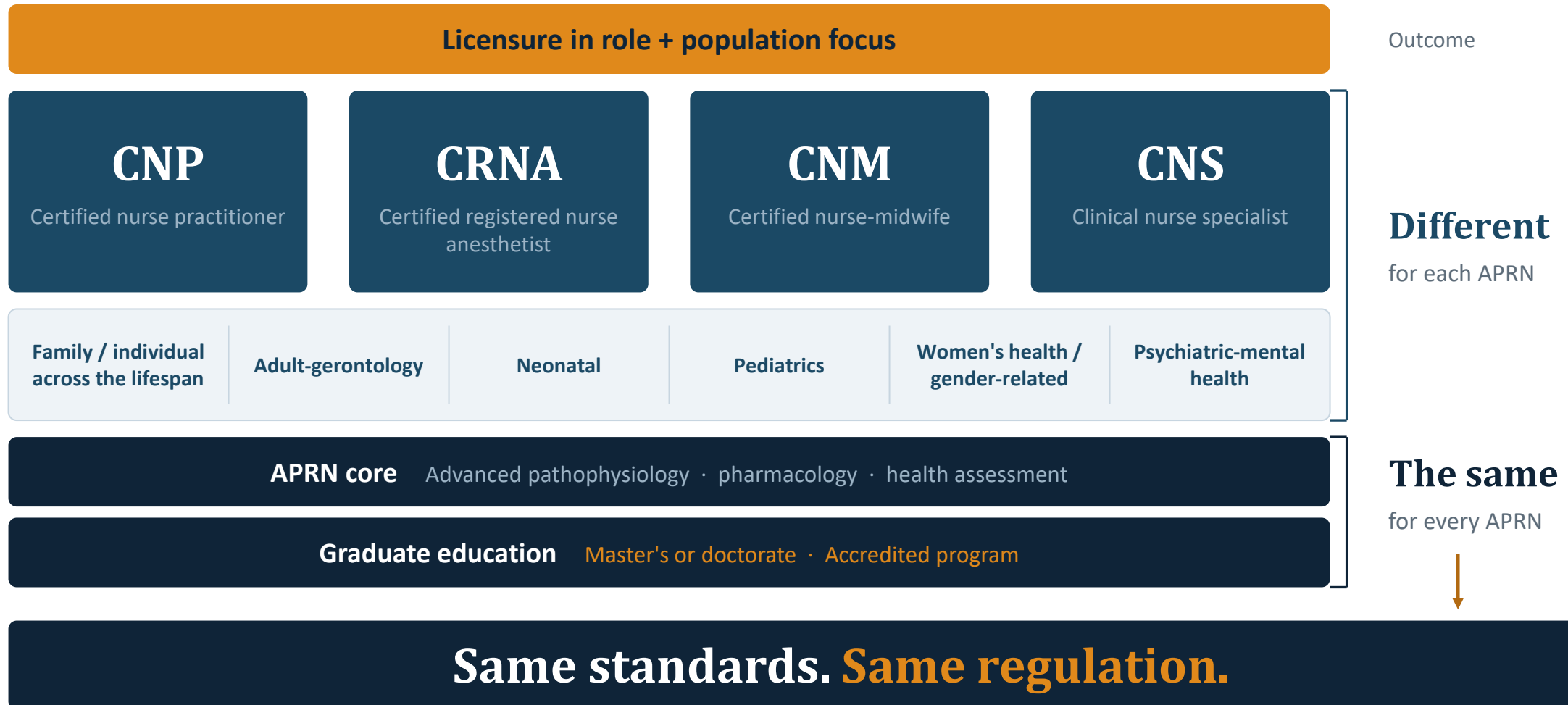
Purchased, not provided

Nebraska certified nurse-midwives report paying physicians a fee to obtain the practice agreement — the signature state law requires before they may practice at all.

What this actually is: a requirement that is purchased, and fulfilled at an average of 279 miles, is not producing clinical oversight at the bedside. It is producing a transaction, and a barrier to practice.

Same foundation. Different paths.

Every APRN is educated to the same standard, then prepared in a role and a population focus.



Nebraska regulates its APRN roles unequally

Full practice authority has already been extended to nurse anesthetists and to nurse practitioners.

NEBRASKA'S OWN RECORD

2002

Nurse anesthetists

Full practice authority granted

2015

Nurse practitioners

Full practice authority granted

Today

Nurse midwives

Physician practice agreement still required

FULL PRACTICE AUTHORITY, 51 US JURISDICTIONS

Nurse midwives

35 of 51



Nurse practitioners

28 of 51



Nurse anesthetists

25 of 51



Nationally, midwives lead all APRN roles in full practice authority.

Nebraska is the **only** jurisdiction that grants full practice authority to both nurse practitioners and nurse anesthetists while still requiring a supervising physician for nurse-midwives.

The proposed language

HOW THE PROPOSAL WAS DEVELOPED

Built with Nebraska's healthcare stakeholders

This proposal was not drafted by nurse-midwives alone, and its language is not invented.

WHO CAME TOGETHER

Physician organizations

Hospitals

Nursing organizations

Maternity quality leaders

Health systems

Practicing Nebraska CNMs

Stakeholder engagement from multiple organizations, and their concerns shaped the transition-to-practice requirement and the out-of-hospital birth provisions.

MODELED ON STATES THAT HAVE ALREADY MADE THE CHANGE

North Carolina, Session Law 2023-14 § 4.3

In force since October 2023, it supplied the template: a defined transition to practice, low-risk eligibility limits, informed consent, and a written transfer plan. The proposal also draws on other states that have recently modernized nurse-midwifery regulation.

N.C. Gen. Stat. §§ 90-178.2 to 90-178.8, as amended by 2023 N.C. Sess. Laws 14, § 4.3.

Two components

Each is evaluated separately against all six statutory criteria.

COMPONENT A

Full Practice Authority

Granted through a structured, phased transition-to-practice pathway, consistent with Nebraska's existing regulatory model for Nurse Practitioners.

Nebraska granted full practice authority to CRNAs in 2002 and to NPs in 2015.

COMPONENT B

Planned home birth authority

Removal of Nebraska's categorical statutory prohibition on CNM-attended planned home birth, replaced with a regulated framework including eligibility and informed consent requirements.

Nebraska is the only state with this prohibition written into statute.

Practice authority: from permanent dependency to transition

The proposal does not remove collaboration with physicians or the health care team.

1984- TODAY

Permanent practice agreement

A written agreement with a supervising physician is required for the whole of a CNM's career, regardless of experience or setting.



PROPOSED — ENTRY

2,000-hour transition to practice

After initial licensure, the CNM practices under a collaborating provider agreement for a defined period of supervised hours.



PROPOSED — AFTER TRANSITION

Independent authority

The CNM practices under authority granted by the Board. Consultation, referral, and transfer continue whenever clinically indicated.

This is the structure Nebraska already applies to nurse practitioners.

Scope: state what CNMs are educated and certified to do

The amendment describes existing practice. It does not extend midwifery into new clinical territory.

AUTHORIZED PRACTICE, AS STATED IN THE PROPOSED LANGUAGE

- Prenatal care
- Labor and birth care for appropriate patients
- Postpartum care
- Immediate newborn care (7 days- national scope is 28 days)
- Gynecologic, reproductive, and episodic care
- Referral and transfer when needs exceed CNM scope or competence

PRESCRIPTIVE AUTHORITY

Written explicitly into the Act

CNMs already prescribe within regulated APRN practice. The amendment states that authority in the Act rather than leaving it to be inferred from the general APRN provisions.

Clarity here reduces disputes later.

Boundary: nothing in this list exceeds the ACNM core competencies or AMCB certification. Some of the components are still quite limited relative to other states. Where a patient's needs exceed the scope or the clinician's competence, referral is required, not optional.

The evidence on full practice authority

A summary of the findings. The full evidence base, with citations and study detail, is in the supplementary report.

SAFETY AND OUTCOMES

- 35 jurisdictions have granted CNMs full practice authority or a pathway to it. None has reversed it.
- Autonomous-practice states: lower adjusted odds of cesarean birth (0.87), preterm birth (0.87), and low birth weight (0.89).
- Meta-analysis of ~1.4 million pregnancies: lower risk across most neonatal morbidity measures; no mortality difference.
- Scoping review of 66 U.S. studies: lower intervention rates and improved satisfaction across all six IOM quality domains.
- Nebraska CNMs are among the least disciplined licensed providers in the state.

ACCESS AND WORKFORCE

- 4.85 CNMs per 1,000 births in full practice authority states, against 2.17 in collaborative-agreement states.
- Midwives present in 46.3% of counties in full practice states against 39.2% in restricted states (p<.001).
- 34% of rural hospitals in FPA states have CNMs attending births, against 28% in collaborative-agreement states.
- Full-practice states more often have above-average density of both midwives and obstetricians (43% vs 19%).
- Nebraska's NP reform was followed by substantial growth in rural NP practice.

AND THE BODIES THAT HAVE REVIEWED THIS AGREE

Federal Trade Commission

Supervision requirements are an anticompetitive restraint of trade with no well-founded safety justification.

National Academy of Medicine

Called for scope-of-practice barriers to be permanently removed.

ACOG

Supports certified nurse-midwives having full practice authority.

Full citations are set out in the Executive Summary: Evidence and Criterion Evaluation, submitted with the application.

How Component A meets all six criteria

1. Present scope inadequately addresses public health, safety, or welfare

Supervision ties practice authority to physician availability, not to competence. Reviewed agreements averaged 279 miles. FPA states have 4.85 CNMs per 1,000 births against 2.17.

2. The change would benefit public health, safety, or welfare

Midwife-led continuity care: fewer preterm births (RR 0.76) and lower combined fetal loss and neonatal death (RR 0.84). 34% of rural hospitals in FPA states have CNMs attending births, against 28%.

3. No significant new danger is created

No new tasks, patient populations, or settings. 35 jurisdictions have granted CNM full practice authority and none has reversed it. Autonomous-practice states show lower odds of cesarean, preterm birth, and low birth weight.

4. Current education and training adequately prepare practitioners

Every function within full practice authority is already taught in ACME-accredited graduate programs and assessed through AMCB certification. No new training or curriculum is required.

5. Post-professional programs and competence assessment are available

The transition-to-practice pathway is modeled on Nebraska's existing NP mechanism: defined clinical hours, a formal transition agreement, and Board review. AMCB certification maintenance continues throughout.

6. Adequate measures exist to assess competence and act on it

Licensure, renewal, complaint investigation, discipline, mandatory reporting, hospital credentialing, and NPDB reporting. None of these depends on a supervision agreement.

Nebraska granted full practice authority to CRNAs in 2002 and to Nurse Practitioners in 2015. It is the only state that has done both without also granting it to CNMs.

Home birth... Is this a dramatic change?

Not really.

Nebraska is asking to do what every other state, and every comparable country, already does.

The only state

Nebraska is the only U.S. state with a categorical prohibition on nurse-midwife attended planned home birth written into statute. Forty-nine states permit it.

An international outlier

In most comparable countries a woman may plan a home birth with a qualified midwife. In several, including the United Kingdom and the Netherlands, it is publicly funded and offered as a standard choice of birth setting.

Not a claim of perfect safety

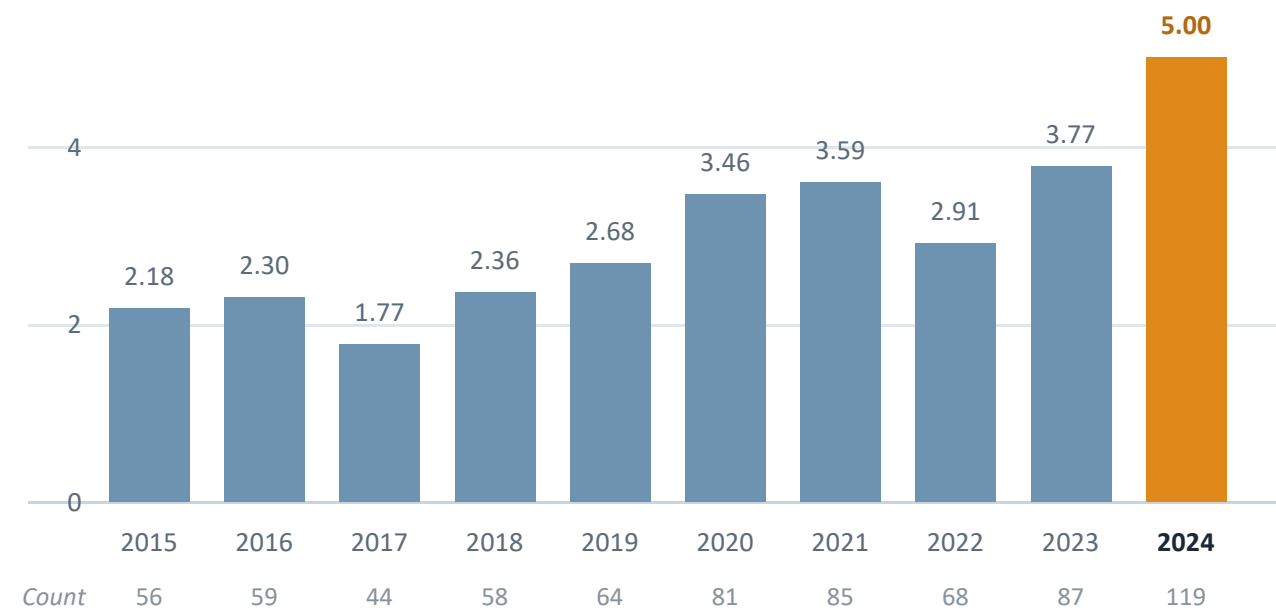
Home birth is not perfectly safe. Neither is hospital birth. It is treated across the developed world as reasonably safe for appropriate pregnancies, and as a decision that belongs to the woman making it.

What is unusual here is not the practice. It is the prohibition.

The prohibition in Nebraska has not prevented home birth

Intended home births in Nebraska, per 1,000 live births, 2015–2024.

Rate per 1,000



+112%

growth in planned home births, 56 in 2015 to 119 in 2024

721

intended home births recorded in Nebraska over the ten years the prohibition was in force

What the prohibition actually does: it does not stop planned home birth. It stops families from choosing the most educated and most regulated midwifery clinician available to attend one — and no other state has found the prohibition necessary.

Nebraska Office of Vital Records, 2015–2024. Over the period, 241,946 total births, 967 home births, and 721 intended home births — an overall intended rate of 2.98 per 1,000.

What the prohibition has prevented

Home birth continued. What never got built was any way for Nebraska to see it, set standards for it, or act on it.

Verification

No credential or disciplinary history for a family to check before choosing an attendant.

Board jurisdiction

No license to investigate, condition, or revoke.

A complaint route

Nowhere for a family to take a concern, before or after.

Competency standards

No required training, no continuing education, no floor.

Outcome reporting

No record of what happens. No data the state can act on.

Transfer planning

No duty to ensure appropriate transfer of care

The prohibition did not stop home birth in Nebraska.

It has left the public without protections

For low-risk pregnancies, home birth outcomes are good

FOR MOTHERS

Consistently fewer interventions.

Lower odds of cesarean, operative vaginal birth, episiotomy, oxytocin augmentation, severe perineal trauma, and maternal infection — with no associated increase in severe acute maternal morbidity in the largest comparative study.

FOR BABIES

Absolute mortality is low.

In large cohorts in well-integrated maternity systems, and in pooled analyses, mortality among low-risk planned home births has not differed significantly from similarly low-risk planned hospital birth.

What the data can and cannot settle. No study randomizes birth setting, so every finding here — favorable and unfavorable — is observational and carries the same confounding. What the studies do agree on is which pregnancies carry the most risk. For the low-risk pregnancies this proposal would allow, the large studies found no meaningful difference in deaths compared with hospital birth.

We are not claiming that home birth and hospital birth are equivalent. We are claiming that selection changes the population, and that the selected population does well.

Is planned home birth as safe for mothers?

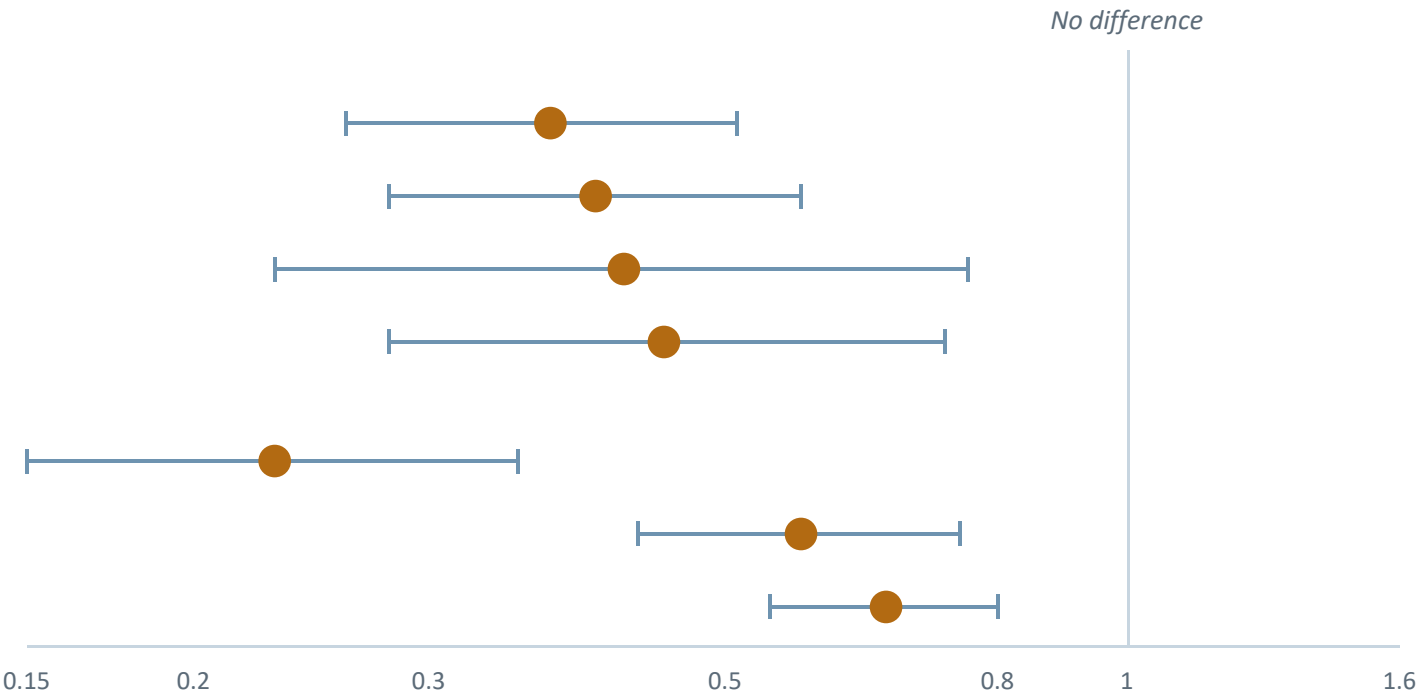
Among low-risk women, planned home birth has consistently been associated with fewer obstetric interventions, and has not been associated with increased severe maternal morbidity.

INTERVENTIONS

Oxytocin augmentation	0.37 (0.26–0.51)
Cesarean birth	0.40 (0.28–0.57)
Operative vaginal birth	0.42 (0.23–0.76)
Episiotomy	0.45 (0.28–0.73)

MATERNAL MORBIDITY

Maternal infection	0.23 (0.15–0.35)
Third/fourth-degree tear	0.57 (0.43–0.75)
Postpartum hemorrhage	0.66 (0.54–0.80)



Odds ratios below 1.0 favor planned home birth. Log scale. Reitsma et al., EClinicalMedicine 2020.

Severe maternal morbidity

In 146,752 low-risk Dutch births, planned home birth was not associated with greater severe acute maternal morbidity. Nulliparous 2.3 vs 3.1 per 1,000 (aOR 0.77, 0.56–1.06).

Stated carefully

Observational comparisons — not proof the setting causes lower intervention. PPH is lower in the pooled analysis but not in risk-ratio studies. No claim is made about maternal mortality because it is too rare to draw estimates.

Is planned home birth as safe for babies?

Not as a single category. Neonatal safety depends heavily on risk selection. Among carefully selected low-risk pregnancies, absolute mortality is low — but U.S. studies are heterogeneous.

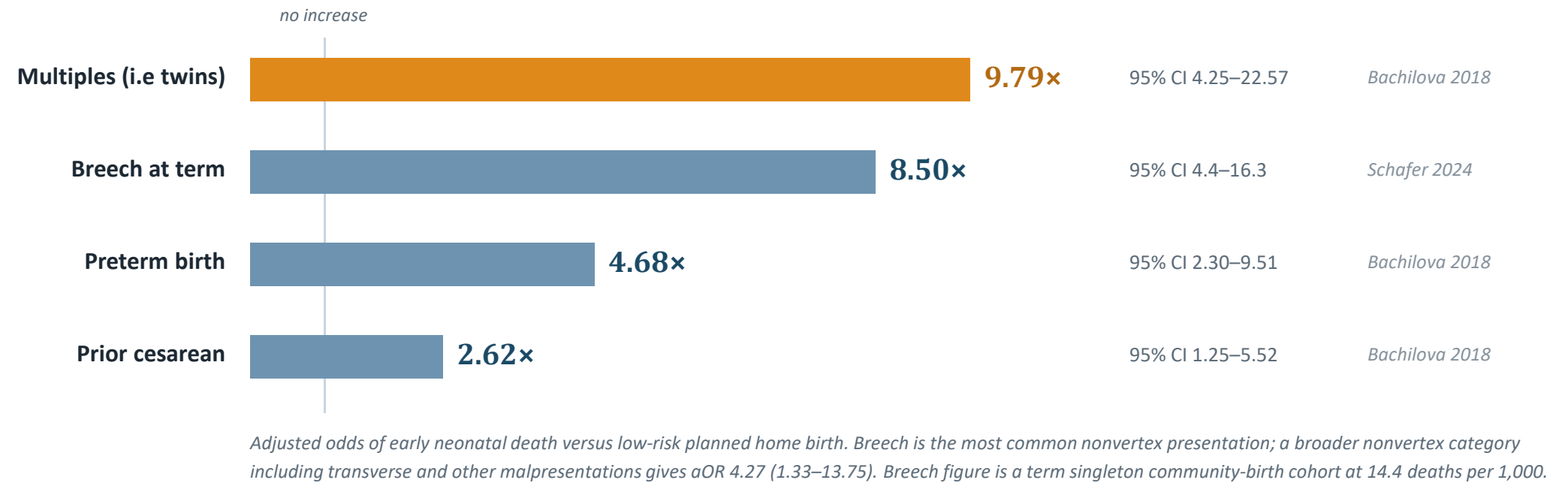
Ontario Hutton et al., CMAJ 2016	11,493 planned home births matched to 11,493 planned hospital births	RR 1.03 95% CI 0.68–1.55	Composite stillbirth, neonatal death or serious morbidity.
Netherlands de Jonge et al., BJOG 2009	529,688 low-risk women beginning labor in primary midwife-led care	RR 1.00 95% CI 0.78–1.27	Intrapartum plus neonatal death through seven days.
Pooled Hutton et al., EClinicalMedicine 2019	Systematic review and meta-analysis, approx. 500,000 intended home births	OR 1.07 95% CI 0.70–1.65	Nulliparous women in well-integrated systems.

What the evidence does not say: U.S. findings are heterogeneous. An Oregon intention-to-treat study of 79,727 term, cephalic, singleton, nonanomalous births found perinatal mortality of 3.9 versus 1.8 per 1,000 for planned out-of-hospital versus planned hospital birth (aOR 2.43, 95% CI 1.37–4.30). That study combined home and freestanding birth-center births.

Because neonatal risk is so sensitive to the characteristics of the pregnancy, the operative question is which pregnancies reduce risk.

What makes planned home birth riskier?

Odds of early neonatal death in U.S. planned home birth, by characteristic of the pregnancy.



An unqualified or absent attendant

Risk rises sharply where no clinician with midwifery training and accountability is present.

WHO · Grünebaum 2017

No connection to hospital care

Where community and hospital care are not connected, outcomes are worse than in integrated systems.

Snowden 2015 · Hutton 2019

All of these variables increase risk in the hospital setting as well. TOLAC, for example, carries a modestly increased perinatal mortality risk in hospitals (~1.7×), yet remains a reasonable option and offers benefits to mothers. Qiu 2023

What makes planned home birth safer?

THE ATTENDANT

An educated, qualified clinician

Accredited graduate midwifery education, national AMCB certification, state licensure, and full Board accountability in every setting.

WHO · ACNM · AMCB



THE PREGNANCY

Careful candidate selection

Singleton, vertex, term, and no significant maternal or fetal complication — assessed through pregnancy and labor rather than once at intake.

Bachilova 2018 · Schafer 2024 · ACOG 697



THE PLAN

A clinician prepared for change

Consultation, referral, and transfer are already part of midwifery scope and of existing Nebraska law. A qualified clinician plans in advance for the birth that stops being low risk.

ACNM Core Competencies · Neb. Rev. Stat. § 38-611

None of this asks the state to invent a new requirement. The attendant is already licensed and certified, the criteria sit in the proposal, and the duty to consult, refer, and transfer is already in Nebraska law.

How Component B meets all six criteria

The comparison is not CNM-attended home birth against no home birth. It is CNM-attended home birth against unregulated home birth, which is already occurring.

1. Present scope inadequately addresses public health, safety, or welfare

The prohibition does not prevent home birth. 721 intended home births were recorded from 2015 to 2024, rising 112%. It prevents only the most qualified attendant from being present.

2. The change would benefit public health, safety, or welfare

Replaces an unregulated environment with a structured one: eligibility criteria, informed consent, and provider standards. A CNM can follow the patient to hospital and continue care there.

3. No significant new danger is created

Measured against the correct baseline — unregulated attendants, no eligibility criteria, no transfer protocol — the framework reduces risk rather than creating it.

4. Current education and training adequately prepare practitioners

Out-of-hospital competencies are core to CNM education: physiologic labor management, risk stratification, hemorrhage, cord prolapse, shoulder dystocia, neonatal resuscitation, and transfer decision-making.

5. Post-professional programs and competence assessment are available

The same infrastructure as Component A, plus emergency skills maintenance — neonatal resuscitation, BLS, and ACLS — and site-specific readiness requirements.

6. Adequate measures exist to assess competence and act on it

Board disciplinary authority is not limited by practice setting. The proposed risk stratification, documentation, and reporting requirements give the Board a richer basis for monitoring.

Nebraska is the only state with this prohibition in statute. No other jurisdiction has found it necessary.

In summary

- Nebraska needs more access to educated and qualified maternity clinicians.
- Certified nurse-midwives are educated, nationally certified, licensed, and accountable clinicians.
- Where midwives lead care, outcomes are good.
- Align Nebraska's laws on homebirth with the rest of the country and world

We ask the Technical Review Committee to recommend the proposal.

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Full citations, study designs, and limitations are set out in the Supplementary Report: Evidence and Criterion Evaluation, submitted with this application.

See the Executive Summary for full citations, source details, and additional evidence.