Nurse-Midwives of America — NMOA

POLICY BRIEF
Practice authority

Full Practice Authority for Nurse-Midwives

Nurse-midwives already have full practice authority in 37 states and D.C., more than nurse practitioners (27 states and D.C.). Obstetricians support extending it to every state.

OBSTETRICIANS AND NURSE-MIDWIVES AGREE

ACOG supports full practice authority for nurse-midwives

"National uniformity in full practice authority and licensure across all states."

Joint Statement of Practice Relations, American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives, revised and reaffirmed November 2022. The statement calls obstetrician-gynecologists and nurse-midwives licensed, independent clinicians. Nationally, ACOG does not advocate for statutory requirements for collaborative practice agreements.

Where the states stand

Full practice authority	AK AZ AR CA CT DC DE HI IA ID KS MA MD ME MI MN MT ND NH NM NV NY OR RI UT WA WI WY	28
Full practice after a transition period	CO FL IL KY NC OK SD VA VT WV	10
Collaborative agreement required	AL IN LA MO MS NJ OH PA SC TN TX	11
Physician supervision required	GA NE	2

What happens in full practice states

4.85 vs 2.17	nurse-midwives per 1,000 births, more than double
46% vs 39%	of counties have a midwife
34% vs 28%	of rural hospitals have nurse-midwives attending births
13% lower	odds of cesarean and preterm birth

Full practice means no required physician supervision or signed agreement. Nurse-midwives stay graduate-educated, board-certified, and state-licensed, and still consult, refer, and transfer care when a patient needs a physician.

OUR ASK

Give nurse-midwives full practice authority, so every family can get maternity care close to home.

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Sources: ACOG/ACNM Joint Statement of Practice Relations (rev. 2022); Nebraska Section of ACOG, letter to the 407 Review Committee (2026); state statutes and regulations, reviewed November 2026; AANP state practice environment; Yang et al. 2016; Ranchoff & Declercq 2020; Kozhimannil et al. 2016; FTC (2014); National Academies, Future of Nursing 2020–2030 (2021).

Nurse-Midwives Keep Birth Close to Home

Rural labor and delivery units are closing. Nurse-midwives help rural hospitals stay ready for birth, so families do not have to drive hours to have a baby.

1 in 3 U.S. counties are maternity care deserts	**58%** of rural hospitals had no obstetric services in 2024	**139** rural hospitals stopped, or announced they will stop, delivering babies since 2020	**Nearly 60%** of recent closures took a county's only birthing facility

WHY RURAL UNITS CLOSE

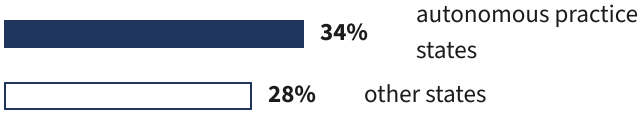
Rural hospitals deliver fewer babies, and administrators report needing at least 200 births a year for a unit to be safe and financially viable. Staffing is one of the most common reasons units close: it is hard to recruit clinicians who can be ready for a birth at any hour.

How nurse-midwives help

- **Experts in birth.** Educated and board-certified to manage labor and birth, sharing coverage with physicians.
- **One clinician, many needs.** Prenatal, birth, postpartum, newborn, gynecologic, and primary care.
- **Already part of rural care.** Nurse-midwives attend births at about one in three rural maternity hospitals.
- **Nurses first.** Nursing skills suited to small units where everyone wears many hats.
- **Wanted by communities.** Rural hospitals in Montana and California recruited nurse-midwives in response to community demand.

Practice laws make the difference

Rural hospitals with nurse-midwives attending births



Two rural hospitals studied by the University of Minnesota Rural Health Research Center credited their midwifery programs' success to the autonomy their states grant nurse-midwives: no restrictive supervision agreements, prescribing authority, and independent clinical decisions, with physician support.

Families in maternity care deserts travel about three times farther to reach labor and delivery care.

OUR ASK

Grant nurse-midwives full practice authority, pay them fairly for the care they provide, and make sure they can hold hospital privileges.

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Sources: March of Dimes, Nowhere to Go (2026); University of Minnesota Rural Health Research Center, Hospital-Level Changes in Obstetric Services, 2010–2024 (2026); Center for Healthcare Quality and Payment Reform (2026); Kozhimannil et al., The Rural Obstetric Workforce in US Hospitals (2015); Kozhimannil et al., The Practice of Midwifery in Rural US Hospitals (2016); UMN RHRC, Midwifery Care at Rural Hospitals in Montana and California (2024).

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POLICY BRIEF
Cost and quality

High-Quality Care, Lower Cost

U.S. research links nurse-midwifery care for low-risk pregnancies with fewer cesarean births and other interventions, strong newborn outcomes, and lower maternity spending.

$2,010
lower Medicaid spending per mother and baby in birth center care

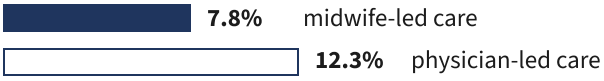
$2,262
lower cost per low-risk birth with midwife-led care (national model)

42%
of U.S. births are paid for by Medicaid

31 states
pay midwives the same Medicaid rate as physicians

Fewer cesareans, strong outcomes

Cesarean birth, low-risk hospital births



No increase in newborn complications (Northwest U.S. hospitals).

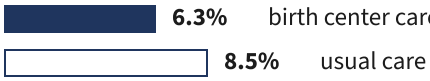
MILITARY HEALTH SYSTEM

Across 136,848 births, low-risk patients cared for by nurse-midwives had lower odds of cesarean birth, labor induction, and birth complications, and higher odds of breastfeeding and vaginal birth after cesarean.

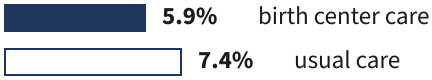
Better results on Medicaid

The federal Strong Start initiative compared Medicaid patients in midwifery-led birth center care with similar patients in usual care.

Preterm birth



Low birth weight



Birth center patients also had fewer cesareans, and Medicaid spent $2,010 less per mother and baby through the baby's first year.

WHERE THE SAVINGS COME FROM

In a hospital study of 1,441 low-risk births, care led by certified nurse-midwives used fewer interventions and hospital resources and had lower total direct costs, with comparable outcomes. A national study of more than 85,000 births in midwifery-based birth centers found cesarean rates 12.2 points lower and NICU admissions 5.5 points lower than similar hospital births.

OUR ASK

Pay nurse-midwives the same Medicaid rate as physicians for the same services, and sustain the birth centers and hospital midwifery services that keep care high in quality and lower in cost.

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Sources: Carlson et al., Birth 2023; Hamlin et al., Policy Polit Nurs Pract 2021; Dubay et al., Health Affairs 2020 (Strong Start); CMS Strong Start evaluation (2018); Altman et al., Women's Health Issues 2017; Attanasio et al., Birth 2020 (modeled estimate); Wallace et al., Health Serv Res 2024; MacDorman & Declercq, Birth 2019; ACNM National Chartbook (2023 state policies).

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POLICY BRIEF
Community birth

Nurse-Midwives Are Experts in Community Birth

For 100 years, nurse-midwives have brought safe birth care to homes, birth centers, and rural communities.

THE MYTH

"Nurse-midwives only know hospital birth."

THE FACT

Every nurse-midwife is educated for home and birth center birth.

BIRTHS ATTENDED BY NURSE-MIDWIVES, CDC FINAL DATA, 2024

30% of midwife-attended U.S. home births	**49.4%** of U.S. birth center births, nearly half	**13,219** home births attended by nurse-midwives	**24,406** home and birth center births in a single year

EDUCATED FOR EVERY BIRTH SETTING

Nurse-midwives are nurses first, trained in community and population health. Every accredited midwifery program teaches birth outside the hospital, and the national scope of practice includes homes, birth centers, and hospitals. Not every nurse-midwife attends home births, but every one is educated for them.

Where it all began

1925
Frontier Nursing Service nurse-midwives ride horseback to home births in rural Kentucky.

1931
The nation's first school of nurse-midwifery opens in New York City.

1975
Nurse-midwives found the first state-licensed freestanding birth center in the U.S.

Strong outcomes, clear safety standards

In the National Birth Center Study II (79 centers, care mostly by nurse-midwives), the cesarean rate was **6.1%**, with **no maternal deaths**. Nurse-midwives bring careful screening, informed consent, and a written transfer plan.

OUR ASK

Let nurse-midwives serve families in every birth setting, with clear safety standards, informed consent, and a transfer plan.

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Sources: CDC/NCHS, Births: Final Data for 2024 (place of birth by attendant); AACN, The Essentials (population health); ACNM, Become a Midwife; ACNM, Definition of Midwifery and Scope of Practice; Frontier Nursing Service; Maternity Center Association records; Stapleton et al., J Midwifery Womens Health 2013 (National Birth Center Study II); American Association of Birth Centers.

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POLICY BRIEF
Education and certification

Educated, Certified, Accountable

Every certified nurse-midwife (CNM) is a registered nurse with a graduate degree in midwifery and national board certification.

The path to becoming a nurse-midwife

Step 1
Bachelor's degree
Required for every accredited program

Step 2
Registered nurse
Licensed RN, often with years at the bedside

Step 3
Graduate degree
Master's or doctorate from an ACME-accredited program

Step 4
National board exam
American Midwifery Certification Board

Step 5
State license
Licensed as an advanced practice registered nurse

8.3 years
average nursing experience before midwifery, about 17,000 hours, in one 2026 state review

Every 5 years
nurse-midwives recertify through board competency modules and continuing education

Global standard
U.S. competencies meet or exceed the International Confederation of Midwives' standards

What nurse-midwives are trained to do

- Prenatal care, labor and birth, and postpartum care
- Care of the healthy newborn through the first 28 days
- Gynecologic, family planning, and preconception care
- Primary care from adolescence through menopause and beyond
- Pharmacology and prescribing
- Recognizing complications early, then consulting, co-managing, or transferring care

Prepared for every setting

- Every accredited program teaches birth outside the hospital.
- Nurse-midwifery is one of four advanced practice registered nurse roles, and the one built around pregnancy, birth, and the newborn.
- Every graduate must demonstrate the national Core Competencies for Basic Midwifery Practice before certification.

WHY IT MATTERS FOR POLICY

Nurse-midwives bring nursing experience, graduate-level clinical education, and ongoing board certification to every patient. Laws that require physician supervision or limit where nurse-midwives practice do not reflect this preparation.

OUR ASK

Let nurse-midwives practice to the full extent of their education, training, and national certification.

Nurse-Midwives of America

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Sources: American Midwifery Certification Board, eligibility and Certificate Maintenance Program; ACNM, Core Competencies for Basic Midwifery Practice; ACNM, Education and Certification position statement; ACNM, Become a Midwife; APRN Consensus Model (2008); International Confederation of Midwives, Global Standards for Midwifery Education; Nebraska DHHS 407 Credentialing Review (2026).