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Medicaid Coverage of Breastfeeding Support and Supplies

Landscape Analysis

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August 2025

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ABOUT HMA

Health Management Associates, Inc. (HMA), is a leading independent national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. Founded in 1985, today we have over 700 consultants and are still growing. We help clients stay ahead of the curve by providing skilled analysis, technical assistance, resources, decision support, and expertise.

ACKNOWLEDGMENTS

This report presents an independent analysis by HMA, based on in-depth interviews and feedback from a range of stakeholders including state Medicaid officials, state and local WIC representatives, lactation providers, managed care organization representatives, community-based organizations, and breastfeeding subject matter experts. The authors thank our partners and their organizations for spearheading this work, including:

Kate Hanson, Founder and Executive Director, Meals4Families (M4F). M4F works to end child hunger in North Carolina by breaking down barriers that prevent families from accessing nutrition support programs including SNAP, WIC, school meals, and free summer meals.

Love Anderson, Co-Founder Breastfeeding Family Friendly Communities (BFFC) of Durham; Parent Liaison of the North Carolina Breastfeeding Coalition. The BFFC initiative in Durham, NC, is a communitywide program designed to improve health equity, as supported by the World Health Organization guideline to work with communities to improve breastfeeding support services. The BFFC brings together stakeholders from diverse backgrounds, organizations, agencies, and institutions to create a more breastfeeding and family friendly community to impact health equity for all families in Durham, NC.

We gratefully acknowledge the following individuals for participating in interviews and sharing their perspectives:

- Brendy Bandy, Executive Director, Kansas Breastfeeding Coalition
- Ryan Bullock, Chief Strategy Officer, Aeroflow Health
- Tricia Cassi, IBCLC, WIC State Breastfeeding Coordinator, Vermont Department of Health
- Kristin Chatfield, Research Analyst, Oregon Health Authority, WIC Program (OHA – WIC)
- Julie Fields, IBCLC, RLC, Beautiful Bonds
- Cassandra Florea, MS, RDN, LD, CLC, Breastfeeding Peer Counselor Coordinator, Kansas Department of Health & Environment, Department, Nutrition & WIC Services
- Brandi Harrison, IBCLC/Doula
- Jess Kimball, CLC, PMH-C, CPT, Certified Birth and Postpartum Doula, Certified Infant Sleep Coach
- Gillian MacKinnon, MS, RDN, IBCLC, Public Health Nutrition Specialist, Vermont Department of Health
- Sheryl McCully, Manager of Physical Health Utilization Management, Colorado Access (COA)
- Taylor Mitchell, CHP+ Program Manager, COA
- Jami Murphy, Care Management Supervisor, COA
- Liz Owens, Vice President of Government Relations, COA
- Anna Patrick, IBCLC, Peer Counselor, Sedgwick County WIC
- Chiara Phillips, State WIC Breastfeeding Coordinator, NC Department of Health and Human Services (NCDHHS), Division of Child and Family Well-Being, Community Nutrition Services Section
- Shelby Powell, IBCLC, Sunflower Lactation
- Julie Reeder, Senior Research Analyst, OHA - WIC
- Cristy Sellers, Director of the Division of Health Advancement, Arkansas Department of Health
- Korina Skaff, Breastfeeding Coordinator, OHA – WIC
- Susanna Snyder, Child & Family Health Division Director, Health Programs Office, Colorado Department of Health Care Policy and Financing (HCPF)
- Dr. Sarah Sobik, Pediatrician, University of Arkansas
- Dr. Anna Strong, Executive Director, American Academy of Pediatrics, Arkansas Chapter
- Catherine Sullivan, Director, Carolina Global Breastfeeding Institute
- Anne Taylor, Director of Provider Recruitment, COA
- Courtney Walker-Borch, MSN, APRN, FNP-BC, IBCLC, Inpatient Lactation Consultant Nurse Specialist, University of Vermont Medical Center
- Kiera Walsh, Senior Managed Care Associate, Aeroflow Health
- Jessica Werner, Lactation Support Services Policy Specialist, Colorado HCPF
- Heather Wilman, Senior Director of Care Management, WellCare
- Kimberly Wilmon, Medicaid Nurse Manager, Arkansas Department of Human Services
- Dr. Misti Virmani, Executive Director and Medical Director, University of Arkansas for Medical Sciences (UAMS) Milk Bank

EXECUTIVE SUMMARY

Breastfeeding is a proven public health intervention with significant short- and long-term health benefits for both mothers and infants, including reduced infant mortality and chronic disease risk.[1,2,3] National guidelines from leading organizations—including the US Department of Agriculture (USDA),[4] American Academy of Pediatrics (AAP),[5] American College of Obstetricians and Gynecologists (ACOG),[6] and the World Health Organization (WHO)[7]—recommend exclusive breastfeeding for the first six months, with continued breastfeeding through at least one year. Despite these clear recommendations and the well-documented health and economic benefits of breastfeeding, coverage of and access to breastfeeding services and supplies is inconsistent and varies across state Medicaid programs. Given that Medicaid finances more than 40 percent of all US births and covers healthcare costs for more than four in 10 low-income, reproductive age women (18–49 years old),[8] ensuring comprehensive and equitable coverage of breastfeeding support and supplies through Medicaid is a powerful strategy to advance maternal and child health equity and improve outcomes nationwide.

The Affordable Care Act's (ACA's) preventive services requirement mandates that states cover breast pumps and lactation consultation services for Medicaid enrollees in those states that have expanded Medicaid to low-income adults with incomes up to 138 percent of the federal poverty level (FPL)—40 states and the District of Columbia as of April 2025. Non-expansion states have no federal requirement to cover breastfeeding services for pregnant or postpartum Medicaid members, although some states may cover these services for Medicaid-eligible infants if deemed medically necessary under the federal Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program.[9] Most state Medicaid programs do cover lactation consultation services and breast pumps,[10] but the states have broad authority to implement utilization controls, prior authorization requirements, provider eligibility and service location requirements, and reimbursement rates, creating a patchwork of coverage policies.

Moreover, Medicaid managed care organizations (MCOs) vary in how they administer lactation benefits. The Women, Infants, and Children (WIC) program, a federally funded program separate from Medicaid, also provides comprehensive breastfeeding services and supplies, including lactation counseling and breast pumps; however, coordination with the Medicaid program, as well as the types of services and supplies available to WIC participants, vary across state and local agencies.

This report presents a landscape analysis examining Medicaid coverage of breastfeeding services and supplies, including lactation consultation services and breast pumps. Through policy review and stakeholder interviews in six states, the study identifies common barriers, implementation gaps, effective practices, and policy recommendations to improve service delivery and outcomes. Table 1 presents a high-level overview of Medicaid policies related to breastfeeding services and supports in our six target states: Arkansas (AR), Colorado (CO), Kansas (KS), North Carolina (NC), Oregon (OR), and Vermont (VT).

Table 1. Overview of State Medicaid Lactation Support and Breast Pump Supplies Policies

State	Medicaid Expansion	12-Month Post-partum Coverage	Lactation Support Benefit	Breast Pump Benefit		
				Pump Benefit Details	Rx or Prior Authorization Requirement	Available Prenatally?
AR	Y	N	Not covered as of early 2025, but 5/2025 legislation mandates coverage of lactation consultation	Not covered	N/A	N/A
CO	Y	Y	Individual & group, in-person/in-home/ telehealth; referral from physician or licensed practitioner required; up to two hours per visit, unlimited visits	Manual, electric, single/double covered, with hospital-grade pump	Rx Prior auth. for hospital-grade pumps	Yes, from the 28th week of pregnancy
KS	N	Y	Max. 5 face-to-face, one-on-one sessions (30 to 90 min.); per child from birth to 90 days old and up to 21 months old when medically necessary; available via telemedicine, office, or home setting; group sessions are not covered	Manual and electric breast pumps (max. 1/year). Breast pump replacement parts (max. 2 of each part/year) Excluded: hospital-grade electric breast pumps and breast shield and splash protector for use with breast pump	Rx	No
NC	Y	Y	Six 15-minute units/day, lifetime max. of 36 units, when medically necessary; individual, face-to-face required	One electric pump/pregnancy; breast pump replacement parts and storage bags	Prior auth. for hospital-grade pump; required for electric breast pumps only if medically necessary	Not specified in state policy, but some MCOs do[11]
OR	Y	Y	Unlimited visits up to six months postpartum	Manual and electric breast pumps	Prior auth. for electric breast pumps	No

State	Medicaid Expansion	12-Month Post-partum Coverage	Lactation Support Benefit	Breast Pump Benefit		
				Pump Benefit Details	Rx or Prior Authorization Requirement	Available Prenatally?
VT	Y	Y	In-home lactation consultation services covered by an IBCLC	One personal use double electric pump/pregnancy; hospital-grade rental when medically necessary; breast pump replacement parts and storage bags.	Rx for personal use double electric Prior auth. for hospital-grade pumps	Yes, 60 days before the projected due date

Barriers and Key Elements of a Successful Breastfeeding Program

This study revealed a set of persistent and interconnected barriers that hinder equitable access to breastfeeding services and supplies among Medicaid beneficiaries. These impediments include restrictive benefit designs, administrative and billing complexities, a shortage of qualified lactation consultants, low beneficiary and provider awareness of covered services, inconsistent support for breast pump selection and use, and fragmented coordination among Medicaid, WIC, MCOs, and other community providers. Together, these challenges limit the ability of low-income families to initiate and sustain breastfeeding during the critical prenatal and postpartum periods, contributing to avoidable disparities in maternal and infant health outcomes.

To address these gaps, the report offers key recommendations to strengthen Medicaid policies and implement breastfeeding services and supplies. A full list is included in the Discussion and Recommendations section of this report and summarized as follows:

1. **Increase awareness** of breastfeeding benefits and Medicaid coverage among beneficiaries, healthcare providers, and community partners.
2. **Expand benefit design** to allow more flexible, timely access to lactation services and pumps—including providing services during the prenatal period as well as in both individual and group settings, offering supports via telehealth, and reducing benefit authorization hurdles.
3. **Simplify administration** by clarifying billing procedures, supporting lactation provider enrollment as Medicaid providers through specific taxonomy codes, and enabling International Board Certified Lactation Consultants® to bill Medicaid independently without a clinician's supervision
4. **Grow and diversify the workforce** through investments in culturally and linguistically representative lactation providers and creating pathways for training and certification
5. **Empower MCOs** to play a more proactive role in promoting breastfeeding, improving service access, and enhancing outreach
6. **Improve coordination** among Medicaid, WIC, MCOs, and community organizations to streamline referrals, reduce duplication, and create a more integrated support system for families

Taken together, these strategies provide a road map for translating coverage into meaningful care, reducing inequities, and ensuring that all Medicaid-enrolled families have the support they need to successfully breastfeed.

Policy Implications

Comprehensive and accessible breastfeeding support through Medicaid is a high-impact public health investment. Full implementation of the recommendations outlined in this report can reduce persistent health disparities, improve maternal and infant outcomes, and ensure that families receive the care and tools they need during one of the most vulnerable and formative stages of life. In North Carolina, the upcoming re-procurement of Medicaid managed care Standard Plans presents a timely opportunity to embed stronger lactation and breast pump benefits into contracts and drive equitable access statewide. Nationally, the enactment of H.R. 1, the One Big Beautiful Bill Act, underscores the urgency of these reforms, as it shifts more fiscal responsibility to states. As states prepare for these financial shifts and tighter budgets, breastfeeding supports could help states save Medicaid dollars by reducing healthcare utilization and associated costs.

Thus, strengthening breastfeeding supports in Medicaid programs should be seen not as an added cost for states, but rather as an evidence-based strategy to improve health outcomes and reduce long-term spending. Framing lactation services as both a health equity imperative and a cost-containment opportunity can help galvanize support for more robust policies—and ultimately deliver better care to families across the country.

BACKGROUND AND STUDY GOALS

Breastfeeding is a critical public health intervention with well-documented benefits for both mothers and infants. Ensuring comprehensive Medicaid coverage of breastfeeding services and supports is essential to advancing maternal and child health equity. Exclusive breastfeeding for the first six months of an infant's life, followed by continued breastfeeding alongside appropriate complementary foods through at least 12 months, is widely recommended by leading medical and public health organizations, including the American College of Obstetricians and Gynecologists (ACOG),[12] the American Academy of Pediatrics (AAP), [13] the World Health Organization (WHO),[14] and the US Department of Agriculture (USDA).[15] Reflecting this consensus, the US Healthy People 2030 goals identify increasing the proportion of infants who are exclusively breastfed for six months and who continue breastfeeding through the first year of life.[16] Breastfed infants are 33 percent less likely to die within their first year than non-breastfed infants[17] and experience significantly lower rates of hospitalization for respiratory infections,[18] as well as reduced risk for numerous chronic conditions throughout life.[19] Mothers also benefit from breastfeeding through decreased risk of breast and ovarian cancers, high blood pressure, and type 2 diabetes.[20] Because it covers a significant proportion of births in the United States, ensuring comprehensive, Medicaid-covered breastfeeding support is a critical lever for improving maternal and child health at scale.

Furthermore, breastfeeding has been shown to reduce healthcare utilization and associated costs. One study found that each breastfed infant saves an estimated $478 in healthcare costs within the first six months alone, including fewer prescriptions and hospitalizations—key drivers of Medicaid spending.[21] State-specific analyses estimate that even modest improvements in breastfeeding rates could yield millions in Medicaid savings annually.[22]

Despite its benefits, the decision to breastfeed is sometimes a difficult one. Many mothers experience significant challenges with breastfeeding including the need to return to work, lack of support and workplace barriers, difficulties getting the baby to latch, low milk supply, physical discomfort or pain, and breastfeeding stigma, among others.[23] These challenges disproportionately affect low-income households and people of color. According to the Centers for Disease Control and Prevention (CDC), the overall prevalence of breastfeeding initiation among infants born in the United States in 2020 and 2021 was 84 percent; however, breastfeeding rates varied significantly by maternal race, with Black and Native American mothers having the lowest rates of breastfeeding initiation and duration.[24,25,26]

Lower rates of breastfeeding are also associated with lower educational attainment and income levels and greater food insecurity and housing instability. Medicaid enrollees also have been found to breastfeed at lower rates than commercially insured women.[27]

Hence, it is important that mothers receive appropriate lactation services and breast pump supplies following delivery and during the postpartum period to initiate and sustain breastfeeding and to ensure that cost barriers do not discourage low-income individuals from accessing these resources if they choose to breastfeed—an essential step toward promoting maternal health equity. Given that Medicaid covers about one in five adult women of reproductive age (18–49 years old), comprehensive coverage for breastfeeding services and supports is critical.

A group of community-based organizations (CBOs) serving low-income families in North Carolina engaged Health Management Associates, Inc. (HMA), to conduct a landscape analysis of breastfeeding supports and supplies in the Medicaid program. The following report incorporates the findings from policy research and interviews with breastfeeding experts across six states. It is intended to serve as a resource that outlines the policy landscape of breastfeeding services and supplies under the Medicaid program. Our research and interviews covered the following topics:

- Covered services
- Credentialing and provider eligibility requirements
- Provision of services
- Billing and reimbursement
- Managed care navigation
- Telehealth
- Distribution of supplies
- The role of Women, Infants, and Children (WIC)
- Barriers and challenges
- Best practices and recommendations

Our collective goal is to develop strategies to increase coverage and access to breastfeeding services and supplies, thereby improving maternal and child health and promoting equitable access to these services for low-income populations.

Medicaid Overview

Medicaid is the US public health program that provides comprehensive healthcare coverage to low-income individuals. As of January 2025, more than 78 million people were enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[28] Medicaid is jointly funded by states and the federal government. The Centers for Medicare & Medicaid Services (CMS) issues broad guidance, but each state administers its own Medicaid program, resulting in considerable variability between states with respect to benefits and eligibility. Moreover, there is variation in how care is delivered, with some states offering (or requiring) the delivery of benefits through managed care organizations (MCOs) and others using a fee-for-service model for all or certain populations of Medicaid beneficiaries. Approximately 75 percent of Medicaid members are enrolled in an MCO.[29]

Medicaid funded 41 percent of all US births in 2023.

In 2023, 26 percent of Medicaid beneficiaries were females in their reproductive years (ages 15–49), and 41 percent of all US births were funded by Medicaid.[30] As of January 2025, 48 states and Washington, DC, have extended Medicaid postpartum coverage to 12 months after delivery.[31] Previously, pregnancy-related Medicaid coverage expired 60 days postpartum. This coverage extension allows parents to continue accessing Medicaid benefits throughout the postpartum period, improving maternal health and reducing healthcare disparities.[32]

Coverage of Breastfeeding Support and Supplies Under the Affordable Care Act and Medicaid

The Affordable Care Act (ACA) of 2010 requires states that expand Medicaid to newly eligible adults (those earning up to 138% of the federal poverty level [FPL]) to cover a standardized, comprehensive package of essential healthcare, including preventive and wellness services. The scope of preventive services is determined by independent expert bodies including the US Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), Health Resources and Services Administration (HRSA)/Bright Futures, and HRSA/Women's Preventive Services Guidelines (WPSI). These recommended services must be provided by both private insurers and Medicaid expansion plans at no out-of-pocket cost (e.g., copays, deductibles, or coinsurance).

Breastfeeding support and supplies are recognized as preventive health services under the ACA and are included in the WPSI guidelines, developed with support from HRSA. WPSI recommends comprehensive coverage of lactation support, including consultations with trained providers and access to necessary equipment such as breast pumps.[33]

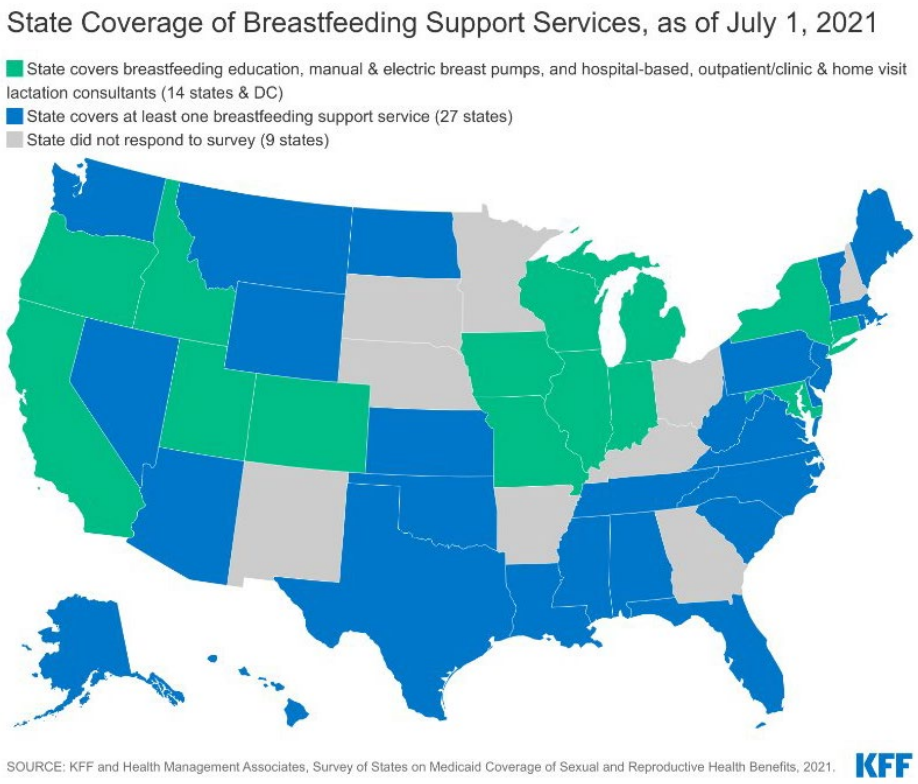
WPSI Guidelines for Breastfeeding Services and Supplies

WPSI recommends comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding.
Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.

In states that have expanded Medicaid—40 states and the District of Columbia as of April 2025—breastfeeding support and supplies are covered benefits under the preventive services requirements of the ACA for the expansion population (low-income adults earning up to 138% of the FPL). For other non-expansion populations, and in the 10 states that have not expanded Medicaid, there is no federal requirement to provide breastfeeding support or supplies through Medicaid for pregnant or postpartum enrollees. In some cases, an infant may qualify for these services under the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, which requires states to cover any services "found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan."[34] However, states are responsible for determining medical necessity on a case-by-case basis. Most expansion states align their benefit packages across their Medicaid populations.

Implementation and enforcement of breastfeeding support benefits vary across all states and among MCOs and fee-for-service (FFS) systems. Although the federal guidance set the standard, state Medicaid agencies and individual payers may interpret or operationalize these rules differently, resulting in uneven access to services across the country. A KFF (Kaiser Family Foundation) study and HMA in 2021 found that 27 state Medicaid programs covered at least one breastfeeding support service, and 15 state Medicaid programs, including the District of Columbia's, covered the full range of services, including breastfeeding education; lactation consultations in the hospital, outpatient, and home settings; and electric and manual breast pumps.[35]

Figure 1. KFF Analysis of State Coverage of Breastfeeding Support Services



Further, states, even in those that expanded Medicaid, have the authority to impose utilization controls and limits on coverage for breastfeeding services, which shape the use and impact of the benefit. States may dictate the type of pump that is covered (i.e., manual, electric, single, double, etc.) and require prior authorization for certain breast pumps. They may also impose quantity limits on the coverage of breast pumps, ranging from one every six months to one per lifetime, according to the 2021 KFF report. States may also control the timing of coverage, such as whether a breast pump can be covered during the prenatal period or only following delivery, and the setting in which the service is provided, such as choosing to cover lactation consultation services provided in the hospital before discharge, at outpatient postpartum visits, at home, or via telehealth.

States also have the latitude to restrict the types of providers that can offer breastfeeding services, such as lactation consultation (e.g., physician, nurse practitioner, advanced practice registered nurse, registered nurse, International Board Certified Lactation Consultants [IBCLC], Certified Lactation Counselor [CLC], etc.). Individual payers, such as MCOs, have the flexibility to impose additional requirements or restrictions, if they meet federal and state minimum requirements, adding to the variation of coverage for Medicaid beneficiaries both across and within states. Finally, some states specify that lactation support services are available for either a mother or the infant, depending on who is Medicaid-eligible. This distinction is important because, in some cases, an infant may be covered under Medicaid but the mother is ineligible or lost coverage postpartum. In such cases, mothers would still be able to receive lactation support, as it is a necessary service to support the baby's growth and development. For example, Colorado specifies in its lactation support policy that services are available for either the mother or the infant.

Federal guidelines (e.g., WPSI) continue to play a key role in defining the scope of breastfeeding-related services that should be covered, emphasizing the evidence-based support for lactation as part of comprehensive maternal and infant healthcare. Still, lack of consistent enforcement, limited provider reimbursement, and administrative barriers remain persistent challenges in translating these guidelines into equitable access on the ground.

A CMS issue brief published in 2021[36] described the variation in state practices and options for improving access to lactation services including encouraging MCOs to collect data and initiate a performance improvement project (PIP) that is designed to increase rates of breastfeeding, eliminate variation in coverage among MCOs, cover lactation services without cost-sharing, and encourage MCOs and other providers to direct patients to Baby-Friendly Hospitals, an initiative established by WHO and UNICEF that has proven to significantly increase rates of successful breastfeeding among Medicaid and privately insured mothers.[37]

The Role of WIC

The Women, Infants, and Children (WIC) program also plays a key role in the provision of breastfeeding services and supports for low-income women, many of whom are eligible for Medicaid. WIC is a federally funded program, administered by the USDA, that provides nutrition support to pregnant and postpartum women up to six months after pregnancy ends, breastfeeding women until the infant turns one year old, and children younger than five years old, including free healthy foods and personalized nutrition education, breastfeeding support, and referrals to other services.[38] To be categorically eligible for WIC, women must live in the state or local service area in which they apply; meet income eligibility requirements set by the state agency (e.g., between 100% and 185% of the FPL) and complete a Nutrition Assessment in which a WIC or other qualified health professional determines whether the individual is at risk for poor nutrition.

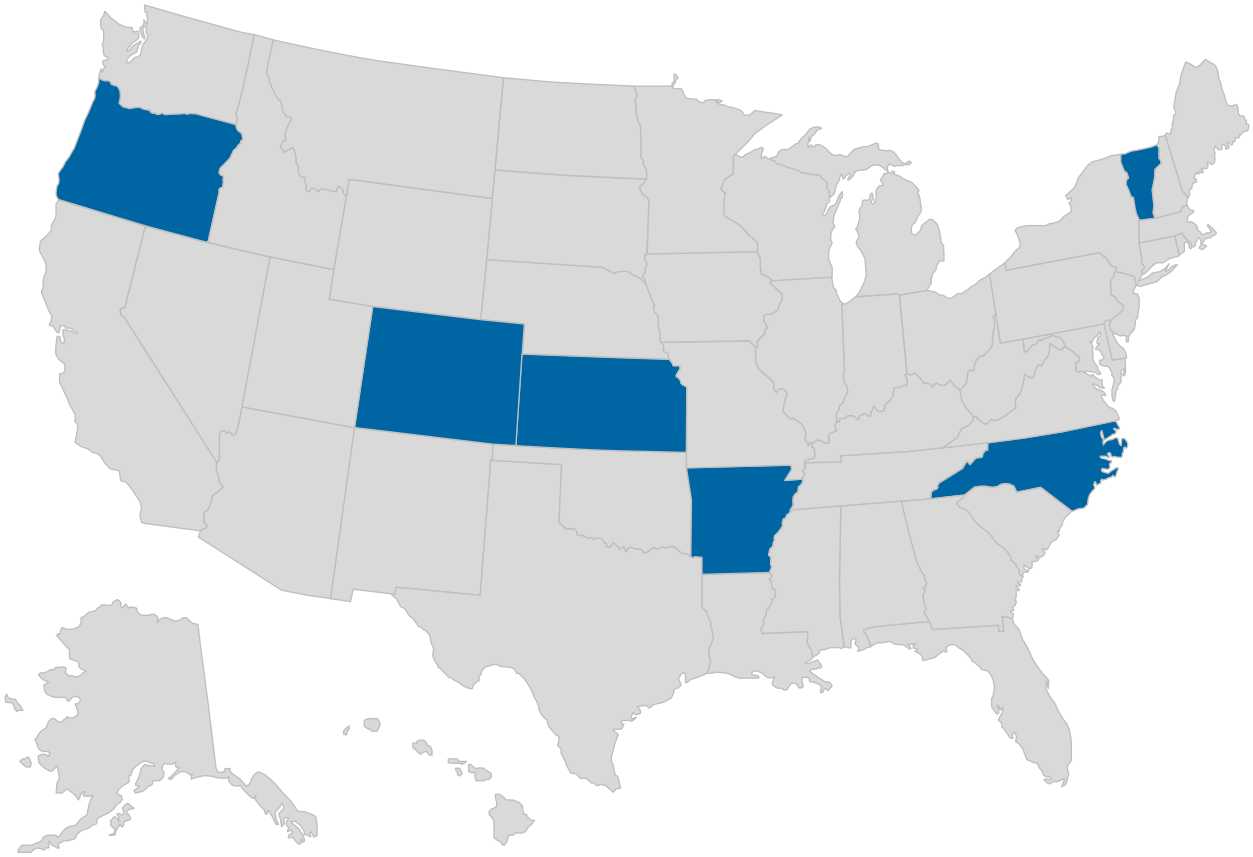
The nation's 89 state and 1,900 local WIC agencies have considerable flexibility to establish policies that govern the services they provide, resulting in variation in WIC resources across and within states. For example, WIC agencies can determine the types of pumps they offer, the criteria that WIC participants must meet to be eligible for certain pump types, staffing, and use of virtual services.[39] WIC also offers a Breastfeeding Peer Counseling Program in which women with previous breastfeeding experience, ideally from the same racial and ethnic background as WIC participants, provide one-on-one support and guidance to breastfeeding mothers. Though the program is federally funded, state agencies allocate peer counseling funds to local agencies and set program standards.[40]

METHODOLOGY

This study included:

- Selection of six states for in-depth study based on criteria seeking variation in geography, Medicaid expansion status, and benefit coverage of breastfeeding support and supplies for Medicaid beneficiaries: Arkansas, Colorado, Kansas, North Carolina, Oregon, and Vermont
- Review of selected states' Medicaid breastfeeding policies, regulations, guidance, and other relevant documents
- Semi-structured key informant interviews with stakeholders in the six selected states, including state officials, representatives of MCOs, WIC agencies, lactation consultants, community groups, and national subject matter experts (SMEs), conducted from February through June 2025
- Analysis of information collected on key themes, barriers and challenges, as well as best practices and recommendations.

Figure 2. States Studied in this Report



“Everybody needs to be able to access this care.”

– North Carolina Lactation Consultant

Medicaid-covered breastfeeding support and supplies provide parents with the tools they need to ensure their babies grow healthy and strong.

FINDINGS: STATE PROFILES ON BREASTFEEDING SERVICES AND SUPPLIES

State Profile: North Carolina

North Carolina has expanded Medicaid and offers extended postpartum Medicaid coverage for up to 12 months post-delivery. As of April 2025, North Carolina had 2,864,717 Medicaid enrollees, 69 percent of whom received their benefits through one of the state's MCOs (i.e., five Standard Plans[41] or four Tailored Plans[42] for individuals with severe behavioral health conditions or intellectual/developmental disabilities) and 28 percent who received their benefits through a Primary Care Case Management (PCCM) program.[43,44]

North Carolina Medicaid covers medically necessary lactation services up to six 15-minute units per day, up to 36 15-minute units per lifetime, and one electric pump per pregnancy with prior authorization. Breast pumps and related accessories were added to the North Carolina Medicaid Nursing Equipment and Supplies Clinical Coverage Policy with medical necessity criteria and prior authorization, effective March 1, 2023. Previously, coverage could be requested on a case-by-case basis as required by EPSDT and the Medicaid home health federal regulations at 42CFR, §440.70. **Table 2** provides additional details about the state's lactation services and breast pump benefits.

Table 2. North Carolina Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description

Medical Lactation Services[45]	• Lactation evaluation and breastfeeding counseling are covered without prior authorization when medically necessary, such as when the infant:
	  ○ Has latch-on difficulties
	  ○ Is premature or a multiple birth
	  ○ Requires breastmilk and the mother-infant dyad needs assistance in the continuation of breastfeeding
	  ○ Has special needs
	  ○ Has jaundice, dehydration, and/or difficulty with weight gain or inappropriate weight gain or loss
	• Medical lactation services are limited to a maximum of six 15-minute units per day with a maximum of 36 lifetime units and must be provided as an individual, face-to-face encounter with the mother-infant dyad.
	• Services must be provided in hospital outpatient clinics; public agencies such as health departments, federally qualified health centers, and rural health clinics; private agencies; physician or medical diagnostic clinics; or physician offices.
	• Qualified providers of medical lactation services include physicians, certified nurse midwives, nurse practitioners (NPs), physician assistants (PAs), or IBCLCs who are either employed or contracted by the physician or physician group or have a referral for an IBCLC consult in another medical practice.
	• All individuals categorically eligible for the WIC program must be referred for nutrition education, lactation support, eligible breastfeeding supplies and supplemental foods; if after required WIC services have been provided, additional medical lactation services are needed they will be reimbursed by Medicaid, if medically necessary.

Benefits	Description

Breast Pump Benefit[46]	• Electric breast pumps are covered with prior authorization when medically necessary, as defined by meeting at least one of the following criteria:
	  ○ During the time a newborn is detained in the hospital after the mother is discharged
	  ○ The newborn has a congenital anomaly that interferes with feeding (such as cleft palate, neuromuscular disease, or congenital heart defect)
	  ○ A medical condition that causes low milk production is present (such as prematurity, thyroid conditions, polycystic ovarian syndrome, diabetes, or obesity)
	• One pump per pregnancy is covered, and hospital-grade pump rentals are also covered if medically necessary (prior authorization limited to one month at a time).
	• Replacement parts and storage bags are covered (i.e., 2 breast pump tubing, 2 adapters for breast pump, 2 caps for breast pump, 2 breast shields and splash protectors, 2 bottles for use with breast pump, and 2 locking rings for breast pump per year; 200 storage bags for breast milk per month.)
	• Many MCOs offer value-added or "extra" benefits, such as a free electric breast pump, milk storage bags, and nursing pillows

Below we describe key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews.

Lactation Services

Barriers and Challenges

Barriers to enrollment and billing for Medicaid services for non-licensed IBCLCs pose operational burdens that limit access. Under North Carolina's Medicaid Dietary Evaluation and Counseling and Medical Lactation Services Clinical Coverage Policy (effective August 15, 2023), IBCLCs must work under direct physician supervision and document medical necessity for each consult. This is despite IBCLCs working within their scope of practice and the fact that lactation support is often preventive in nature. Stakeholders assert that this requirement stems from a misunderstanding of the difference between certification and licensure: IBCLCs earn national board certification through the International Board of Lactation Consultant Examiners (IBLCE) and do not need state licensure to practice safely and effectively within their scope.

Stakeholders further shared that because North Carolina Medicaid's Provider Permission Matrix—which the state uses to process provider enrollments—lacks a dedicated taxonomy code for non-RN IBCLCs, board-certified lactation consultants can neither enroll in nor bill Medicaid directly. Instead, they must bill incident to a licensed practitioner, which interviewees suggest creates unnecessary administrative hurdles and limits access to care. In contrast, one stakeholder reported that some states such as Virginia, Tennessee, and Georgia have recognized IBCLCs as stand-alone Medicaid providers by adding the appropriate taxonomy codes, allowing them to deliver preventive lactation services without physician oversight.

The absence of lactation consultants in MCO provider directories may create access barriers. One stakeholder confirmed that no in-network lactation consultants were listed in some MCO provider directories and that members were likely accessing lactation support services through obstetric and pediatric offices, where IBCLCs can bill under the Medicaid-credentialed physician. This system could create access barriers, as members are unable to search for this provider type in the directory and would need to know to contact their obstetrician or pediatrician for services.

A shortage of lactation support providers is exacerbated by language, transportation, and geographic barriers. The pool of lactation support providers is sparse, and those who can provide care in languages other than English is even more limited. Further, many parts of North Carolina are rural, with few local providers, compounded by the ongoing recovery from Hurricane Helene, which hit the state in September 2024. Further, interviewees asserted that Medicaid reimbursement rates are low, limiting the number of providers who can serve enrollees.

There is ambiguity regarding telehealth coverage for lactation support. Several interviewees noted it is unclear whether telehealth lactation consultation visits are reimbursable. Exceptions that allowed telehealth coverage were made during the COVID-19 public health emergency, but clear guidance has not been issued about the continuation of this policy.

Interviewee Recommendations and Best Practices

North Carolina Medicaid should add a non-RN IBCLC taxonomy code to their Medicaid Provider Permission Matrix and remove the requirements for physician supervision of IBCLCs and individual medical necessity documentation for routine preventive lactation services. These policy changes would align North Carolina Medicaid with peer states, streamline credentialing, reduce administrative burden, and expand direct access to high-quality lactation care for all enrollees.

Expanding the benefit limit, service locations, and appointment options can improve access. A provider suggested that Medicaid cover at least six lactation consultant visits, starting in the prenatal period. Further, coverage for lactation support through group appointments such as newborn classes, home visits, peer counseling, and telehealth would offer more opportunities to access the services. One stakeholder suggested that states should consider changing their benefit design to cover lactation visits for the duration of breastfeeding without limitation, sharing that most women only attend three classes on average, but other women would benefit from additional support.

Beneficiaries need to be informed about Medicaid coverage for lactation services and how to access them. Interviewees noted that parents often are unaware that they are eligible for lactation support benefits. Infant feeding issues require immediate attention, and it is difficult to get the support needed quickly without a clear understanding of what Medicaid covers. Improving enrollee education through prenatal lactation appointments and classes could help parents identify problems early so they can advocate for and find support in a timely manner.

Maternal health collaboratives can augment state efforts to promote breastfeeding and reduce inequities. One interviewee highlighted the NC Perinatal Health Equity Collective (PHEC), which includes over 200 public, nonprofit, and private sector partners,[47] as a valuable resource for addressing inequities and improving infant and maternal health across the state. According to the NC Department of Health and Human Services, Division of Public Health, website, NC PHEC leads the development of the state's Perinatal Health Strategic Plan (PHSP). The 2022–2026 PHSP identifies several breastfeeding-related goals, including: strengthening the breastfeeding support workforce through increased enrollment in lactation training programs and increased reimbursement; promoting access to comprehensive breastfeeding education and support services, such as medical lactation services; and supporting the creation of a statewide 24-hour breastfeeding support hotline.[48]

Some MCOs offer additional lactation support services as value-added benefits. Carolina Complete Health has a virtual doula and/or breastfeeding benefit for members who are expecting a baby or who have delivered within the last 12 months. UnitedHealthcare Community Plan of North Carolina offers free 24/7 virtual breastfeeding support for new moms as a value-added benefit.[49]

Breast Pumps and Supplies

Barriers and Challenges

The North Carolina Medicaid requirements for prior authorization and medical necessity of breast pumps adds a barrier to access for enrollees. Most enrollees receive prior authorization from their obstetrician, and some durable medical equipment (DME) vendors will facilitate this process. However, some interviewees shared that the authorization process is administratively burdensome to providers and DME providers and unnecessary given the relatively low cost of an electric pump (approximately $150). They also shared that this additional step reduces and delays access to breast pumps.

Further, under North Carolina's DME policy, coverage for electric and hospital-grade breast pumps is contingent on a determination of medical necessity. This determination requires a woman or her newborn to meet one of the following criteria: the newborn is detained in the hospital after the mother is discharged, the newborn has a congenital anomaly that interferes with feeding such as a cleft palate, or the mother has a medical condition that causes low milk production. Stakeholders noted that under this requirement, the baby must have been born, preventing distribution of a breast pump before the infant's due date, as well as a medical reason for its coverage, creating additional barriers for women seeking to breastfeed upon delivery but who do not meet these criteria. One interviewee said that many MCOs, which provide coverage for most Medicaid enrollees in the state, pay for breast pumps before delivery without imposing medical necessity requirements. Nonetheless, approximately 30 percent of beneficiaries are in FFS, leaving them subject to state minimum requirements.

Breast pump coverage and distribution are inconsistent across payers. Interviewees noted that payers have inconsistent policies about which pumps are covered, when they can be ordered (some requiring waiting until after delivery/birth), and how they are distributed, making it difficult for Medicaid enrollees and those who serve them to get accurate information.

"…[I]f somebody is pregnant, and they say they want a pump, they should get it."

Interviewee Recommendations and Best Practices

Breast pump education can be improved through engagement from Medicaid, health plans, providers, and community groups. Interviewees stressed that enrollees first need to be aware of the benefit and then be able to find an in-network provider to help them learn how to set up, operate, clean, and maintain the pump. Education about the benefit should be enhanced across public and private entities. Stakeholders suggested that MCOs should proactively contact pregnant beneficiaries to inform them of benefits available not only to support their prenatal care, but also their breastfeeding and postpartum needs. Lactation consultants can provide critical education on pump use, which is best done during the prenatal period.

The Role of WIC in North Carolina

Individuals are not required to use WIC services before accessing the Medicaid benefit. Because individuals' experiences may differ from what is intended or mandated in policy, we verified with interviewees whether the Medicaid policies are consistent with how lactation support is received in the community. Stakeholders shared that in their experience Medicaid enrollees do not have to go through WIC before receiving Medicaid services, despite stipulation in NC Medicaid policy (see Table 1 in the Executive Summary). Beneficiaries may receive medical lactation services through Medicaid, but WIC cannot bill Medicaid for these services. Further, WIC's breastfeeding support services rely primarily on peer counselors, rather than IBCLCs and advanced practice clinicians, as required in the NC Medicaid medical lactation services policy. Therefore, WIC participants who are ineligible for Medicaid experience a gap in services should they need medical lactation therapy with an IBCLC.

Stakeholders noted that breast pump distribution criteria differ between WIC and MCOs, and even across some WIC agencies. For example, the WIC agency serving the Eastern Band of Cherokee Indians has a different pump supply than other local offices and requires parents to complete all prenatal appointments before providing them with a pump postpartum.

State Profile: Vermont

Vermont has expanded Medicaid and offers extended postpartum Medicaid coverage for up to 12 months post-delivery. As of April 2025, Vermont had 156,642 Medicaid and CHIP enrollees who received benefits through the Department of Vermont Health Access.[50] Vermont has no full risk MCOs in its Medicaid program.

In 2023, Vermont Medicaid expanded breast pump coverage to allow pregnant members to receive a breast pump up to 60 days before their projected due date and up to 120 days postpartum. They also may receive one personal use double electric breast pump per pregnancy. Previously, women only became eligible following the birth of their infants and were limited to one new breast pump every three years.[51] Medicaid enrollees may receive unlimited in-home lactation support from an IBCLC, and inpatient lactation consultation services are available to those who deliver in a hospital, and some pediatric offices and obstetricians offer outpatient lactation support. Telehealth is an option as well. Table 4 provides details about the state's lactation services and breast pump benefits.

Table 3. Vermont Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description
Medical Lactation Services[52]	• Vermont Medicaid enrollees are entitled to in-home lactation consultation services provided by IBCLCs who are licensed, working within the scope of their practice, and enrolled in Vermont Medicaid. • The policy does not provide a limit on the number of visits.
Breast Pump Benefit[53]	• Personal use double electric breast pumps are covered for pregnant and postpartum members with a prescription and when clinical criteria are met (i.e., parent plans to breastfeed or exclusively pump). • Hospital-grade pumps can be rented monthly for infant or maternal members, if medically necessary; prior authorization is required. • One pump per pregnancy is covered. • Pumps are available 60 days prior to the projected due date and up to 120 days postpartum. • Replacement parts and storage bags are covered (i.e., 2 breast pump tubing, 1 adapter for breast pump, 2 caps for breast pump, 2 breast shields and splash protectors, 2 bottles for use with breast pump, and 2 locking rings for breast pump per pregnancy; 100 storage bags for breast milk per 30 days.)

Following is a summary of the key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews.

Lactation Services

Barriers and Challenges

Limited access in rural areas can be a barrier to care. Vermont is designated as a rural state, with almost two-thirds of its residents living in rural areas.[54] Stakeholders noted that in-home support is sometimes inaccessible (or unwelcome), and travel can be especially difficult during the winter months. Further, some patients lack access to transportation. While telehealth is an option, providers noted that it can be a poor substitute for in-person support.

Licensure requirements limit the number and diversity of providers. Stakeholders highlighted that Vermont does not have a licensure process for IBCLCs, so providers must have an additional credential such as a nursing license (e.g., RN or nurse practitioner [NP]) to meet the licensure criteria in the Medicaid lactation policy. IBCLCs must also be enrolled in Vermont Medicaid. In addition, it was noted that most providers are White women who only speak English, potentially contributing to cultural and language barriers, especially in more diverse areas of the state like Burlington.

Interviewee Recommendations and Best Practices

Vermont has a collaborative provider community that allows Medicaid, WIC, hospitals, and other providers to collaborate to improve education and access to services. For example, WIC hosts an annual conference that is free for providers to improve cross-training and collaboration among attendees. Additionally, as WIC staff learns of Medicaid access issues from their local district offices, they communicate with Medicaid to make improvements. For example, Medicaid changed its policy so enrollees could get their pumps prenatally, as do people with commercial coverage. One provider also shared that Vermont Medicaid put together a helpful booklet of lactation-specific services and providers that patients receive upon discharge, so they know where to go if they need additional support.[55]

> “There's just so much value to collaborating locally.”

Breast Pumps and Supplies

Barriers and Challenges

Prior authorization and prescription requirements can present barriers. Providers expressed that these requirements are a "waste of time" because breast pumps are a necessary tool for an infant's nutrition and should always be approved. One provider remarked about how challenging it can be to get a hospital-grade pump rental; the medical necessity criteria outlined in the breast pump DME limitations policy[56] can be so difficult to meet that they feel it is almost not worth the effort.

Interviewee Recommendations and Best Practices

Policy change is easier in a small state where stakeholders know each other and when Medicaid is receptive to provider recommendations. For example, providers and advocates succeeded in changing the breast pump coverage policy from one pump every three years to one pump per pregnancy in 2023.[57] The state also aligned the policy with commercial insurers and now allows members to get the pump during the prenatal period, rather than waiting until after delivery. This ensures members have a pump when they need it and can become familiar with how it works before the baby arrives. Interviewees reported that Vermont Medicaid enrollees can generally access a pump easily, with several DME vendors offering pumps and supplies.

Barriers to breastfeeding supports and supplies should be removed, especially for the first two weeks after delivery. Lactation support providers stressed that it should be easy for everyone to get a quality pump during pregnancy and immediately after delivery, as it is a critical time to establish breastfeeding.

> ***"Equalize access to effective, efficient, quality pumps."***

The Role of WIC in Vermont

WIC fills gaps in breastfeeding support and pumps. WIC has an active role in providing breastfeeding support and services in Vermont, especially when filling in the gaps, such as when a Medicaid enrollee misses the window to order their Medicaid-covered breast pump or if their pump breaks or doesn't work well for them. To get a pump through WIC, the parent must be exclusively breastfeeding or pumping and complete a post-delivery visit with WIC. It can take a week or two to get an appointment.

In addition, WIC provides peer counselor lactation support. Some offices have IBCLCs, and services are available in-person at their clinics and via telehealth. WIC offers support to patients who have lost coverage or are dually eligible for Medicaid and Medicare. WIC also provides group and peer-based support as well as online and app-based education and resources. Interviewees reported that WIC and Vermont Medicaid have a collaborative relationship, allowing for information sharing and quick changes, when needed.

State Profile: Arkansas

Arkansas has expanded Medicaid coverage, but it is exclusive of 12-month postpartum Medicaid coverage.[58] The state limits Medicaid coverage for pregnancy-related services to 60 days post-delivery. As of April 2025, Arkansas had 820,916 Medicaid and CHIP enrollees,[59] 43 percent of whom receive their benefits through their Primary Care Case Management (PCCM) program and [60,61] 4.7 percent of whom receive care through one of the state's four MCOs; the remaining 52.4 percent are served in the state's FFS program.[62]

Arkansas Medicaid historically has omitted coverage for lactation services or breast pump benefits (Table 6). Instead, Arkansas Medicaid and health plans refer patients seeking access to a breast pump to WIC. Legislation passed in April 2025 (HB 1333/Act 627[63]), however, mandates that Medicaid and commercial insurance plans "offered, issued, renewed, delivered, or extended in the state on and after January 1, 2026," include coverage for breastfeeding and lactation consultation services. The state will create a new provider type to allow lactation support services to be billed to Medicaid. As of summer 2025, the state is in the implementation planning phase, incorporating provider outreach and education to build out the details regarding the benefit, utilization limits, provider certifications, and more.

Table 4. Arkansas Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description
Medical Lactation Services[64]	• Arkansas Medicaid does not cover lactation services. • Act 627 calls for coverage of breastfeeding and lactation consulting services from an IBCLC or a certified lactation counselor under supervision of a contracted and in-network healthcare provider; as medically appropriate outpatient or hospital services, during pregnancy and through the extended postpartum period. Additional provisions to be developed.
Breast Pump Benefit	• Arkansas Medicaid does not cover breast pumps and supplies.

Below we describe key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews. Because Arkansas Medicaid was not covering breastfeeding support services or pumps at the time of our interviews, the discussions and findings presented below focus largely on the services provided through the state's WIC program.

Lactation Services

Barriers and Challenges

Stakeholders discussed barriers to lactation consultation services for Medicaid beneficiaries given that the state Medicaid program has not historically covered breastfeeding supports and services. More specifically, they noted the difference in income requirements between Medicaid and WIC,[65] suggesting that women with Medicaid coverage and incomes above the WIC eligibility requirement may fall into coverage gap for lactation support services.

The state's rural geography and workforce challenges were cited as presenting significant barriers to both hospital-based and WIC office lactation services access. Private companies and a small number of hospitals provide lactation support on a self-pay sliding scale or at no charge. The WIC program in Arkansas provides lactation support services and has a state hotline to connect people to lactation support services, though only some WIC counselors have an IBCLC or CLC certification. Furthermore, workforce challenges were widely identified as the most significant barrier to immediate support, particularly for people whose primary language is not English. Arkansas WIC is developing a telehealth platform to improve access to lactation support across the state.

Stakeholders highlighted a lack of breastfeeding supports available in Spanish and other prevalently spoken languages in communities across the state. They also noted the specific needs of the large Marshallese population (i.e., individuals born in the Marshall Islands) in the northern part of the state. One interviewee reported confusion about whether Marshallese individuals are eligible for Medicaid, even though federal and state legislation granted their Medicaid eligibility in 2021, which could affect their access to newly covered lactation support services.[66]

Interviewee Recommendations and Best Practices

Interviewees are looking forward to the implementation of the new state legislation allowing lactation providers to bill Medicaid, as it incorporates some of their key recommendations. They highlighted that the implementation process will be a learning experience in the state, and they anticipate that Medicaid guidance for providers and collaboration will increase access to these services. In addition, they noted that outreach materials for providers of lactation support and other health and social services, enrollees, and other referral sources are still in development and will play a key role in supporting implementation. Interviewees felt that identifying best practices may be premature given the changes coming to the state but are open to sharing information and learning from other states as implementation progresses.

Interviewees recommended investment in the lactation support provider workforce, including training for IBCLCs/CLCs. They also highlighted the need for education and training across the healthcare provider sector to improve mutual understanding and support for breastfeeding and strengthen referral networks.

Breast Pumps and Supplies

Because Arkansas Medicaid was not covering breastfeeding support services or pumps at the time of our interviews, the discussions and findings presented below focus largely on the services provided by the state's WIC program.

Barriers and Challenges

Despite the enactment of the legislation enables providers to receive Medicaid reimbursement for lactation support, breast pumps are not covered benefits, and WIC requirements can pose barriers. The primary distribution channel for breast pumps and supplies for Medicaid recipients in Arkansas continues to be the WIC program. Interviewees described challenging eligibility requirements to receive a breast pump through WIC, including that women need to be breastfeeding at least 50 percent of the time, they can only access the pump after giving birth, and they need to apply and be certified WIC participants before receiving a pump, which creates delays in access. One stakeholder reported it can take as many as six weeks to receive a pump through WIC, and in the past year, WIC programs in certain areas of the state have experienced pump shortages.

Additional barriers to accessing a breast pump include stigma, transportation issues, the need to return to work, and limited flexibility in WIC office assignments. Lactation providers expressed barriers that cause parents to struggle with breastfeeding initiation and duration, including the fact that breastfeeding is less common in Arkansas. In fact, stakeholders suggest that breastfeeding is considered a taboo topic in the state, even among many healthcare providers, suggesting a need for increased advocacy and education. The legislature's passage of the breastfeeding bill was considered a major success, given the difficulty getting some legislators to even discuss breastfeeding and related issues. In addition, the inability to obtain a pump before delivery and the requirement to obtain a pump at their local WIC office, even if they give birth in a different region, present barriers to many women.

Interviewee Recommendations and Best Practices

Interviewees recommended coverage of breast pumps and supplies through the state Medicaid program and greater flexibility in WIC requirements. They specifically called for flexibility in the timing of WIC enrollment and pump pickup so that families could access pumps earlier and obtain them from a WIC office near their birthing hospital. Other stakeholders emphasized that Medicaid coverage for breast pumps is the best way to provide flexibility and promote equity for low-income families and advocated for more breast pump options. Currently, there is only one pump available through the WIC program, which interviewees reported is not the best fit for everyone.

Some interviewees expressed a positive outlook on the recent policy changes, calling them a promising opportunity to develop a program from scratch with current support for maternal health from the governor's office. Other anticipated maternal health initiatives in Arkansas include doula and community health worker reimbursement and remote patient monitoring.

State Profile: Kansas

Kansas has not expanded Medicaid but does offer extended postpartum Medicaid coverage for up to 12 months after delivery. As of April 2025, KanCare, the state's Medicaid and CHIP program, had 413,091 enrollees,[67] 98 percent of whom receive their benefits through one of the state's three MCOs.[68]

Kansas Medicaid covers lactation support services and breast pumps, including up to five lactation counseling sessions per child, and manual and (non-hospital-grade) breast pumps. Table 8 provides additional details about these benefits.

Table 5. Kansas Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description

Medical Lactation Services[69]	• Primarily intended for mothers with children from birth to 90 days old (postpartum or corrected for gestational age); however, it may be available to mothers with children 21 months old and younger when medically necessary.
	• The service includes a face-to-face visit of at least 30 minutes that includes:
	  ○ A comprehensive feeding assessment related to lactation
	  ○ Interventions that address positional techniques, proper latching, and counseling
	  ○ Community support information
	  ○ Evaluation of interventional outcomes
	• Lactation counseling is allowable via telemedicine either in office or home setting.[70]
	• This service is covered only if it is a one-on-one session. Group sessions are not covered.
	• Counseling sessions are limited to five is per child, with each session lasting up to 90 minutes. This service limit may be exceeded based on medical necessity.
	• Medical lactation services provided in hospital outpatient clinics, physician or medical diagnostic clinics, and physician offices must be performed by either:
	  ○ Physicians, certified nurse midwives (CNMs), NPs, PAs, and Local Health Departments (LHDs) that have training and experience providing medical lactation services
	  ○ IBCLCs who are employed by the physician or physician group

Breast Pump Benefit[71][72]	• Breast pumps and replacement parts are covered for all female KanCare members ages 12–55.
	  ○ Manual and electric breast pumps are covered with a limit of no more than one pump per year.
	  ○ Breast pump replacement parts are covered with a limit of no more than two of each per year (pump tube, adapter for pump, cap for pump bottle, polycarbonate bottle for use with pump, locking ring for pump).
	• Hospital-grade electric breast pumps and breast shield and splash protector for use with breast pump are excluded from coverage.
	• A prescription written by a physician is required.

Below we describe key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews.

Lactation Services

Barriers and Challenges

Kansas IBCLCs are not recognized as independent Medicaid providers. Kansas Medicaid policy states that IBCLCs must be "employed by the physician or physician group."[73] Unlike doulas, who can bill independently, IBCLCs must be affiliated with hospitals, clinical offices, or other facilities that are eligible to bill, significantly limiting access to lactation support services for Medicaid beneficiaries. Interviewees reported that some lactation support providers attempt to bill Medicaid independently, but, because they are unaffiliated with a hospital or clinician office, they receive no reimbursement.

Further, confusion about the recognized provider types eligible to bill for lactation support services under the state Medicaid program may impede access. Although lactation services are accessible through various channels (home, hospitals, clinics, etc.), confusion exists regarding who is qualified to provide and bill for these services under the state Medicaid program. State Medicaid guidelines on lactation billing are limited and confuses place of service and provider eligibility. For example, KMAP's updated guidance on lactation counseling from October 2022 adds local health departments (LHDs) to the list of eligible provider types, including physicians, CNMs, nurse practitioners NPs, physician assistants PAs, and LHDs with training and experience in providing medical lactation services.[74] However, it does not clarify who within an LHD may provide the service for Medicaid reimbursement.

Low reimbursement rates are a key barrier to access for Medicaid beneficiaries. In September 2023, the Kansas Department of Health and Environment (KDHE) increased the reimbursement rate for lactation counseling (S9443) to $40 from $9.91 per visit.[75] While this is an improvement, some interviewees noted it remains insufficient to support providers' overhead and labor and does not compensate for travel time or expenses when consultants must make home visits. This gap in payment significantly inhibits the expansion of access to lactation services, especially in rural areas where home visits may be the only feasible option. Compounding this issue is the use of Current Procedural Terminology (CPT)[76] codes with no distinction between various levels of provider expertise. Both mid-level providers with basic training and IBCLCs are treated similarly in billing, which is not reflective of the differences in training or scope of work.[77]

There is a lack of awareness among both providers and beneficiaries about available lactation services covered by Medicaid. Communication breakdowns exist between payers, providers, and policymakers. Although advocacy efforts are under way, changes in state-level Medicaid processes can be slow and unclear, often resulting in outdated or misunderstood policies.

"In a perfect world, anyone that is working with birthing moms, starting with the obstetrician, would contract with an IBCLC in office or hospital and make it part of the prenatal consult."

Kansas Medicaid beneficiaries experience disparities in access related to culture, language, geographic location, internet connectivity, and documentation status. Kansas is a highly rural state, which creates significant access issues to many services including lactation counseling. While telehealth helps address this gap, stakeholders report that some individuals lack reliable internet connections or feel comfortable using remote services. They further noted that the online Medicaid enrollment process also poses a barrier for people without internet access. While navigators can assist, their bandwidth is limited, and navigation programs are subject to funding cuts. Applicants face burdensome documentation requirements, including uploading income verification and rental agreements, which pose barriers for many families. Interviewees also highlighted language barriers that limit access to care. Southwest Kansas has a large Hispanic/Latino population—approximately 50–70 percent in some counties;[78] however, there is a significant shortage of diverse, culturally aligned, and Spanish-speaking lactation providers.

Entering the lactation support workforce is challenging. While some organizations provide scholarships for training, financial support alone is insufficient to address the workforce shortage. Stakeholders shared that aspiring IBCLCs must complete 500 clinical hours (often unpaid) and a $700 exam. Without paid internships or apprenticeship pathways, entering the profession remains inaccessible to many.

Interviewee Recommendations and Best Practices

Interviewees recommended that the state Medicaid program recognize IBCLCs and mid-level lactation counselors as independent provider types. Removing the requirement for certain providers to be employed by physician practices would increase access to lactation support services.

Stakeholders expressed the need for clear, standardized CPT codes for lactation services that reflect the true value and scope of work performed by lactation consultants. Interviewees recommended improved clarity around these codes, particularly to ensure they are widely recognized and reimbursable under Medicaid (and private insurance) and reimbursed at rates that support a livable wage, including operational overhead such as billing staff and administrative costs. Some stakeholders identified the use of CPT code S9443, which enables billing for lactation support services by a non-physician provider, as a best practice.

MCOs can increase access to breastfeeding supports. Although MCOs in Kansas must adhere to uniform policies under the KMAP contract, they can offer additional value-added benefits to increase access for their members. For example, one MCO has contracted with both English- and Spanish-speaking IBCLCs to operate a lactation helpline for members—an important example of culturally responsive and accessible support. MCOs have engaged with stakeholders by participating in monthly dedicated meetings to discuss lactation billing procedures. One stakeholder described MCO representatives as responsive and collaborative, highlighting positive working relationships that could be leveraged to further expand access to services and address billing challenges more proactively.

Interviewees called for lactation counseling to be embedded in obstetric care settings and a broader culture change among healthcare providers. Interviewees suggested allowing IBCLCs to collaborate with OB/GYNs and other prenatal providers, with referrals or in-house services offered during routine prenatal checkups. One interviewee, however, said that many physicians do not yet view lactation support as a critical prenatal service, highlighting the need for provider education and culture change within healthcare systems.

Breast Pumps and Supplies

Barriers and Challenges

Medicaid-covered pumps are often of lower quality and limited in selection. Medicaid MCOs in Kansas contract with DME vendors to provide covered breast pumps to beneficiaries; however, DME vendors offer wide variation in product quality and choice. Stakeholders reported that clients frequently receive pumps through Medicaid MCOs that are not well suited to their needs. Medicaid often only covers the cost of a basic pump, which may be incompatible with the client's needs or lifestyle, and any upgrades or accessories (e.g., pumping bras or higher quality models) may require out-of-pocket costs that exceed retail prices. Some come with only one flange size (often too large), causing discomfort or ineffective milk expression. Though WIC budgets for flange inserts and offers custom fittings, the initial product quality remains an issue.

Stakeholders report that a lack of in-store DME options, proliferation of breast pump brands, and the influence of social media further challenges Medicaid beneficiaries in obtaining the best breast pump for their needs, particularly non-English speakers. Interviewees reported that due to low Medicaid reimbursement rates for breast pumps, many brick-and-mortar DME providers no longer stock breast pumps on shelves, and the two DME storefronts in Wichita have limited options. As a result, they report that families must rely on online ordering, which introduces delays and confusion, especially for those unfamiliar with the process or lacking internet access. Many clients are ill-equipped to choose a pump that fits their needs, especially when they receive conflicting or misleading information from social media platforms like TikTok or Instagram. This challenge is exacerbated by the recent proliferation of breast pump brands, which are often marketed via social media, further overwhelming beneficiaries. Further, although some DME vendor websites have a language line, and even offer classes to support women in choosing a breast pump, many are offered only in English, which creates a barrier for non-English speaking clients trying to order pumps online.

Requiring beneficiaries to obtain and provide a prescription for breast pumps to the online DME vendor website can be a barrier, especially for individuals with limited or no internet access. This administrative step is particularly problematic in rural areas, where reliable access to devices and connectivity is not guaranteed, as well as for individuals with low digital literacy. Some DME providers, however, will collaborate directly with the prescribing clinician to obtain the prescription at the back end.

Changes to MCO participation in the Medicaid market have created challenges for beneficiaries. WIC staff noted confusion and delays in pump distribution and coverage verification when new MCOs enter the market under the KanCare system, especially when attempting to use the online portal or secure timely delivery through DME suppliers.

Interviewee Recommendations and Best Practices

Breast pumps should be covered for each birth without limitations on timing (e.g., once per year). Kansas Medicaid's policy of providing only one pump per year—even in the case of multiple births—is restrictive. Stakeholders report that this policy contrasts with some private insurers that offer a pump per birth.

Increase reimbursement rates for breast pumps. To provide more breast pump options to Medicaid beneficiaries available in-person and online through DME suppliers, stakeholders recommend paying a higher reimbursement rate to keep breast pumps on the shelves at DME storefronts and offer higher quality and a greater variety of pumps.

Implement a breastfeeding hotline for individuals and providers seeking breastfeeding support and information. Many other states have already implemented breastfeeding hotlines that are staffed by IBCLCs, available 24/7, and offer interpretation or language line services. One interviewee expressed her desire to replicate this hotline model in Kansas.

The Role of WIC in Kansas

WIC agencies across Kansas play a critical role in supporting breastfeeding families through education, individualized care, and access to breastfeeding supplies. According to interviewees, Medicaid MCOs are unofficially considered the primary distribution channel for beneficiaries in Kansas. Nonetheless, WIC staff frequently provide pumps in urgent cases—such as when Medicaid-provided equipment fails or when clients are undocumented or face delays. Kansas's WIC policy allows any actively breastfeeding participant—whether exclusively or partially breastfeeding—to receive a breast pump; however, WIC distributes pumps only after delivery, so pregnant individuals must wait to receive them. Eligibility for WIC services is income-based and is independent of Medicaid status or US citizenship. However, despite WIC eligibility rules that do not require proof of citizenship, many undocumented individuals are not accessing services. Providers report a noticeable decrease in utilization among these populations, likely because of fear, confusion, or misinformation.

Although the state maintains a standardized WIC policy on breast pump access, implementation varies significantly by county. Local WIC agencies are responsible for determining the brand and type of pump distributed, whether manual or electric (single- or multi-use). Manual pumps are more commonly issued because of funding constraints. Some agencies do not distribute pumps at all, although a recently introduced USDA training initiative, which includes a hands-on breastfeeding component, has led to an increase in pump distribution across many sites. Recipients are asked to return the pump after one year for cleaning and potential reuse. Although no formal enforcement mechanism is available for individuals who fail to return the pump, it is documented in their record.

Education and lactation support are central to the WIC program's approach. Before receiving a pump, clients meet with trained WIC staff—such as peer counselors, registered nurses, or nutritionists—for personalized, hands-on education. All WIC staff, from front desk personnel to registered dietitians, must complete USDA-certified breastfeeding training. This training includes four levels tailored to job responsibilities and covers pump use, assembly, troubleshooting, and client support. It is intended to complement, but not replace, professional certifications such as the IBCLC credential.

Though each clinic is required to have a designated breastfeeding expert, the individual does not necessarily have to be an IBCLC; a mid-level lactation provider, nurse, or dietitian may serve in this role. Staffing varies by agency, and ongoing efforts are under way to map existing IBCLC placement and develop regional roles to increase access in underserved areas. Staff provide breastfeeding education during pregnancy and proactively contact clients shortly after delivery to offer support. Clients may receive an unlimited number of WIC lactation consultations. Many agencies continue providing support beyond the first year postpartum, particularly for weaning or during subsequent pregnancies.

Despite the critical role WIC plays in supporting breastfeeding families, coordination with Medicaid, particularly KanCare and its MCOs, remains limited and informal. Interviewees report no direct coordination between KanCare and the WIC program except for referrals. WIC staff do not bill Medicaid but provide guidance to help clients access pumps through their MCO's DME vendors. WIC staff help clients navigate online ordering systems on their MCO's DME vendor websites, a process that may take up to two weeks for order fulfillment. In urgent cases, clients may be referred to supply stores, although options are limited and sometimes inaccessible, as noted previously. Staff are instructed not to duplicate services ("double dip"), meaning they do not help clients bill insurance for WIC-funded pumps or lactation support services.

State Profile: Colorado

Colorado has expanded Medicaid and offers extended postpartum coverage for up to 12 months post-delivery. In April 2025, a total of 1,223,788 Coloradans were enrolled in Health First Colorado, the state Medicaid program, and 85,598 were members of Child Health Plan Plus (CHP+), the CHIP program.[79] Through the state's Accountable Care Collaborative (ACC) program, Medicaid beneficiaries are enrolled in a Regional Accountable Entity (RAE) administered by health plans considered to be managed care entities.[80] Members are connected to a Primary Care Medical Provider (PCMP) that serves as their medical home. The separate CHP+ program is a full risk managed care delivery system, with four health plans covering children through the age of 18 and pregnant people with household income up to 260 percent of the FPL who are ineligible for Medicaid.[81]

Colorado Medicaid and CHIP programs cover lactation services and breast pumps. Table 10 provides additional details about the Medicaid benefits. Interviewees indicated that the Medicaid benefit is used as the guide to operationalize these services for the CHIP program as well.

Table 6. Colorado Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description
Medical Lactation Services[82,83,84,85]	• Lactation supports are covered for pregnant and postpartum members and the child who is breastfeeding throughout pregnancy and up to 12 months after delivery. • The benefit requires electronic or written recommendations from physicians or other licensed practitioners of the healing arts acting within their scope of practice. • The services may be provided individually, in a group setting, via telehealth as well as several other settings (e.g., office, home, hospital, homeless shelter, etc.). • There is no limit on the number of visits, which are billable for up to 2 hours each. • Services may be provided by an MD/DO, PA, CNM, RN, CPM, DEM, Certified Midwife, APN, RN enrolled as a Medicaid provider offering in-scope services. Starting December 1, 2024, IBCLCs, CLCs, and Certified Lactation Educators (CLEs) could enroll as Medicaid providers to provide lactation support services.[86] IBCLCs may practice without supervision and bill directly, but CLCs and CLEs must have supervision from an enrolled MD/DO, PA, APN, CNM, or IBCLC and may not bill directly. • Rates vary by setting (individual vs. group) but not provider type.
Breast Pump Benefit[87]	• Manual and electric single-user pumps are covered without prior authorization, but must be prescribed by MD/DO, PA or NP (as with all DME) and obtained from approved suppliers (primarily pharmacies and DME providers). • Multi-user pumps require prior authorization indicating medical necessity. • The benefit is available from the 28th week of pregnancy.

Below we describe key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews.

Lactation Services

Barriers and Challenges

The state has a shortage of IBCLCs, exacerbated by Medicaid provider enrollment, billing, and reimbursement challenges. Most interviewees noted that the Medicaid provider application process for newly eligible lactation support providers is lengthy and difficult, though the state reported it is working to make enrollment resources available. The health plan noted it provides guidance on enrollment whenever it identifies potential lactation consultants.

The health plan also described that once enrolled, some providers were confused about how to bill for services. State interviewees shared that initially, there was an issue with the lactation service billing code that limited the number of units billed. Recognizing this problem, the state added a code modifier to allow for additional units (up to 2 hours per visit); however, there appears to be continued confusion about CPT codes specific to lactation services. A health plan reported it does not have any contracted lactation consultants or educators under the associated provider types, citing lack of a dedicated CPT code, which makes pinpointing these providers a challenge. Stakeholders added that the IBCLC reimbursement rate is low compared with private health insurance and self-pay options, despite extensive training and certification requirements, further limiting IBCLC participation.

The requirement of a referral from a licensed practitioner often creates a barrier. A lactation provider noted that many women “give up” once they learn they need a written referral from a physician. This situation is most common among people postpartum with a newborn, especially if they have postpartum depression or they are having challenges with breastfeeding.

Many beneficiaries are unaware of this benefit. Interviewees noted insufficient education about Medicaid coverage of lactation services among beneficiaries, physicians, and even lactation providers.

> “People do not know where to go or that they have the benefit until there is a problem.”

Lactation support is less available at home and in rural areas. Fewer IBCLCs and other providers are in rural and certain counties, posing an access barrier for people who live in these locations. An interviewee noted that lactation support services are easier to access while a member is still in the hospital after delivery, and it is more difficult to access in-home services that require lactation providers to incur transportation costs.

Interviewee Recommendations and Best Practices

Medicaid breastfeeding policies should be responsive to input from key stakeholders. Medicaid officials emphasized the value of a five-month stakeholder engagement and landscape review that they conducted before developing their lactation policy. This process included learning from providers, WIC staff, consultants, and beneficiaries from across the state to understand what was working and the barriers faced on the ground, which enabled them to design the best policy for both people who access services and those who provide services.

An extended eligibility period increases the likelihood of successful breastfeeding. Interviewees cited learning from beneficiaries and providers about the importance of offering the lactation support benefit to pregnant people (prior to delivery) to set the stage for breastfeeding initiation. Similarly, because challenges can arise throughout the entire breastfeeding journey, the state understood the value of making the benefit available postpartum and for pediatric members to maximize the availability of these support services to those who might need them. One interviewee recommended ***eliminating the requirement for a referral*** from a licensed clinician, as that extra step is often a barrier.

Expanding the range of eligible lactation providers enhances access to services. State interviewees described learning early in the stakeholder engagement process about the array of lactation providers and their education and skills. For example, they learned about IBCLCs' extensive education and experience, resulting in a policy that allows IBCLCs to provide lactation support services without supervision or secondhand licensure.[88] Also upon learning about the limited number of IBCLCs in some communities, the state allows trained lactation counselors and educators to provide the services, albeit under supervision.

> ***"We learned the importance of not limiting but expanding care."***

Flexibility in the length and number of visits promotes effective lactation support. Noting that individuals have unique needs and challenges, interviewees found that 15-minute billing units, up to a two-hour limit per visit, and without limits on visits, offer beneficiaries and providers the time they may need for services to be effective. After an early challenge with claims coding, the state added a modifier for length of time, which allows up to the two-hour visit. One interviewee noted that unlimited visits allow lactation support to be a preventive service that can avert a crisis, rather than a reactive service after a situation arises.

Members need greater education about the benefits of breastfeeding as well as coverage and access to lactation supports. Interviewees cited the need for health plans and providers to better educate the public about the benefits of breastfeeding for both mothers and their children. Greater efforts also are needed to inform Medicaid beneficiaries that lactation supports are covered benefits and how to access those services. For example, the state should create a ***directory of lactation providers*** and disseminate it to physician offices, health plans, and WIC offices to share with members.

Lactation providers and physicians need to be informed about the benefit and Medicaid participation. Interviewees noted the importance of the state sharing policy updates, provider enrollment instructions, and billing protocols with physicians and lactation providers via emails, meetings, and other venues. They also called for more outreach to lactation providers to assist them with enrollment in the program.

Telehealth could be used to greatly expand access to lactation support services. Telehealth was cited an underutilized service that could address the shortage of providers, especially in rural areas and other provider deserts.

"Telehealth offers massive opportunity to improve lactation support access."

Breast Pumps and Supplies

Barriers and Challenges

Requiring a prescription could pose a barrier. Covered as a preventive service, breast pumps and supplies require a prescription from an MD/DO, PA or NP, which a provider indicated could delay receipt of the device. State interviewees reported that they are exploring ways to streamline this process. Others, however, noted that a prescription is typically needed for DME and ensures members are receiving proper care and require the use of a breast pump.

The DME cap for CHIP benefits could be an obstacle. A health plan noted that breast pumps are subject to the $2,000 annual limit under the DME benefit for CHP+. If beneficiaries are attempting to access a breast pump in addition to other DME supplies, they could run into issues with denials as the result of exceeding the benefit limit. A representative of a health plan that distributes breast pumps through DME vendors also noted that the limited number of DME providers that supply breast pumps can inhibit access.

Interviewee Recommendations and Best Practices

Colorado Medicaid's policy does not require prior authorization for manual or single-use pumps, which stakeholders noted improves access. Interviewees noted that requiring authorization would be an unnecessary obstacle to obtaining a breast pump and should be avoided, except for multi-user pumps that are more expensive and on rental.

The Role of WIC in Colorado

Frequent communication between Medicaid and WIC can promote complementary support and reduce replication. WIC staff provided input on the development of Colorado Medicaid's lactation policies, which interviewees said improved the benefit design. Further, Colorado Medicaid and WIC staff meet monthly to share their insights and experiences with the benefits as well as to avert duplicative payment for the same services or supplies. For example, beneficiaries might access a breast pump through Medicaid but go to WIC for supplies; sharing information enables staff to help members make those connections.

Medicaid is officially the primary payer of breast pumps, but in practice, women obtain pumps through either WIC or Medicaid. State interviewees noted that WIC asks if individuals tried to access other sources (Medicaid) first, but that no formal verification process is in place. A lactation provider was unaware that Medicaid is the primary payer and shared that people obtain pumps through either program. A health plan representative noted CHP+ members can still access breast pumps through WIC or through their health plan. Health plans would not cover breast pumps provided by WIC.

State Profile: Oregon

Oregon is a Medicaid expansion state and offers extended postpartum Medicaid coverage for up to 12 months post-delivery. The Oregon Health Authority (OHA) administers the Oregon Health Plan (OHP), the state's Medicaid and CHIP program. As of April 2025, Oregon had 1,312,501 Medicaid and CHIP enrollees,[89] 91.5 percent of whom receive their benefits through one of the state's 18 Coordinated Care Organizations (CCOs).[90] CCOs are local managed care health plans that help members navigate their benefits and receive coordinated care.

Medicaid covers lactation support services for pregnant and postpartum women, and breast pumps and supplies postpartum. Table 12 provides additional details about these benefits.

Table 7. Oregon Medicaid Lactation Services and Breast Pump Benefits

Benefits	Description
Medical Lactation Services[91,92]	• Oregon Medicaid enrollees are entitled to lactation support services (including education and counseling by trained providers) for pregnant and postpartum women, up to six months postpartum. • Registered Nurse/Nurse Midwife/OHA-licensed lactation consultants including IBCLCs can independently bill but CLC/peers must be under the supervision of a qualified provider. • There is no maximum number of visits.

Breast Pump Benefit[93,94,95]	• Oregon Medicaid enrollees have access to breast pumps and supplies postpartum when a pump is necessary to establish or maintain milk production to maximize the availability of breast milk to the baby.
	• Manual breast pumps are covered without prior authorization.
	• Electric breast pumps are covered with prior authorization if determined medically appropriate for the infant or mother in alignment with the defined conditions or if a hand pump or manual expression has been tried for one week without success in mothers with an established milk supply.
	  ○ Electric breast pump rentals cannot exceed 60 days.
	  ○ Electric breast pumps can only be purchased when cost-effective for one of the following conditions: cleft palate or lip; cranial-facial abnormalities, inability to suck adequately, or infant is separated from the mother for an undetermined length of time.
	• Pumps should be provided within 24 hours to allow for continued milk production when medically indicated.
	• The following services are not covered:
	  ○ Accessories
	  ○ An electric breast pump for the comfort and convenience of the mother
	  ○ Supplemental Nutrition System (SNS)
	  ○ Heavy duty, hospital-grade breast pumps
	  ○ Replacement parts

Below we describe key challenges and best practices related to lactation services and breast pump policies, respectively, based on stakeholder interviews.

Lactation Services

Barriers and Challenges

Interviewees reported that Medicaid is supposed to be the primary payer for lactation support in Oregon; however, they noted a lack of understanding about CCOs cover. Some stakeholders noted that while Medicaid provides pumps, sometimes the provision of lactation support services ends up falling on WIC due to a lack of clarity about roles and responsibilities and lactation workforce challenges. Because Oregon has 15 regional CCOs, interviewees discussed challenges coordinating across all payers, including barriers to partnership with community organizations.

Workforce challenges are evident across the state; many counties have no IBCLCs/CLCs. Medicaid only reimburses IBCLC-certified providers and does not cover other providers such as lactation educators and peer counselors. However, interviewees noted that many regions lack IBCLCs. Interviewee discussed the fact that Medicaid beneficiaries often receive their pump from the CCO, often through the mail without any wraparound support to educate them about how to use it. Each hospital has a different approach to providing lactation support services, and many are overcapacity and short-staffed.

Interviewees reported that cultural norms and stigma prevent families from feeding their infants in the way that best works for them. One stakeholder noted that although many families would prefer to breastfeed, which is the default in Oregon, it does not always work for them, so having flexibility to breastfeed, use formula, or a combination of the two is more realistic.

"I wish there was more flexibility for breastfeeding, formula, or a combination, since that is the reality for a lot of people. A lot of families' first choice is breastfeeding, but it does not work for everyone."

Interviewee Recommendations and Best Practices

Interviewees noted the importance of Medicaid recognizing and reimbursing all lactation provider types, and ensuring all stakeholders are informed of coverage policies. Interviewees recommended that coverage extend beyond IBCLCs to other lactation support providers and noted the need to ensure stakeholders understand and uphold the policies in place.

Breast Pumps and Supplies

Barriers and Challenges

Breast pump delivery must be timely; however, there are challenges with authorization through Medicaid for breast pumps and replacement parts. Stakeholders noted that the Oregon Medicaid DME program has experienced some challenges with timely authorization of electric breast pump rentals, recognizing that this is a time-sensitive need.

Interviewees spoke about variation in quality and lack of guidance and regulation of the type of breast pumps that CCOs provide to Medicaid beneficiaries. Stakeholders note that beneficiaries often go to WIC when their CCO-provided pump breaks, and they need a replacement. In addition, although personalized sizes of supplies are often needed (e.g., flanges), Medicaid does not cover these and other accessories. Stakeholders are advocating to revise Medicaid policies related to coverage of breast pump accessories and breast pump replacement and repair.

Interviewee Recommendations and Best Practices

Interviewees spoke about the importance of partnership and relationship building between all stakeholders. Collaboration between state agencies and community partners, including WIC, Medicaid, and other programs, is deemed vital and should be enhanced.

Interviewees spoke about single-user pumps as the most cost- and time-effective practice. The distribution and tracking of multi-user pumps was described as more time-consuming and costly than single-user pumps because of the increased need for cleaning, maintenance, and ensuring participants return them.

One stakeholder called for the development of guidelines and standards for quality breast pumps. Given the challenges they have seen related to the quality of pumps provided to Medicaid beneficiaries through their CCO, stakeholders report that establishing quality standards for breast pumps will improve breastfeeding initiation and duration.

The Role of WIC in Oregon

WIC plays a vital role in addressing gaps left by Medicaid in providing breast pump replacements and parts and identifying lactation needs for beneficiaries. Though WIC is not the primary provider of breast pumps, the program is sometimes able to provide breast pumps in a quicker, more flexible way. As a result, some local WIC agencies loan or replace pumps when Medicaid or CCOs are unable to act quickly, placing an emotional and logistic burden on postpartum individuals navigating broken equipment and bureaucratic processes. WIC representatives also reported that staff often diagnose lactation needs with their clients and refer them to Medicaid.

Even though both the WIC and Medicaid departments are part of OHA, there are opportunities for improvement around coordination between Medicaid and WIC. Oregon has both a workgroup and a memorandum of understanding between OHA partners including WIC and Medicaid to better coordinate services. Medicaid and WIC are working and learning together to better align their services, such as who is the primary payer for breast pump supplies and replacement parts. Stakeholders report that including Medicaid agency representatives on WIC advisory boards has facilitated progress, such as securing coverage for WIC visits under Non-Emergency Medical Transportation (NEMT).

Relationships between local WIC agencies and CCOs differ significantly across the state. Some local WIC agencies maintain strong ties and partnerships with CCOs, while others lack formal or functional collaboration. Some CCOs show strong collaboration and understanding of Medicaid policy and billing regulations for breastfeeding services, whereas others face challenges in adoption and practice. Successful integration depends on WIC and Medicaid learning to "speak each other's language." WIC stakeholders suggested that elevating WIC from a food assistance role to a recognized component of the medical home requires framing it as an allied health service, including proper use of ICD-10 risk codes.

DISCUSSION AND RECOMMENDATIONS

This study gathered perspectives of multiple stakeholders in six states that reflected different Medicaid lactation support and supply policies and environments. Although each state has unique circumstances and experiences, many common access barriers as well as best practices and recommendations for successful lactation programs emerged.

Barriers to Lactation Supports and Pumps

Medicaid and CHIP beneficiaries face numerous challenges when accessing lactation support services and pumps, including:

- **Benefit restrictions**. Limits on lactation visits or pump type, medical necessity documentation, period of eligibility, service location, telehealth coverage, types of service providers, and prior authorization, referral, or prescription requirements
- **Billing and administrative challenges**. Lack of IBCLC licensing by the state, inability for IBCLCs to bill independently, lack of CPT codes or clarity around IBCLC billing, difficulty enrolling as a Medicaid provider; delays in Medicaid authorization for pumps and replacement parts
- **Lactation Consultant workforce shortages**. Insufficient supply of lactation providers, especially IBCLCs, exacerbated by low reimbursement rates; rural areas with transportation challenges and limited internet connectivity; cultural and language barriers, resulting in access disparities
- **Lack of awareness about coverage and the benefits of breastfeeding**. Insufficient education and outreach for beneficiaries, lactation providers, health and social service providers; stigma; outdated or misunderstood policies; absence of lactation consultants in MCO provider directories
- **Inconsistent quality and guidance in choosing breast pumps**. Variable pump and replacement part coverage, distribution, and quality across payers, and lack of guidance or support for beneficiaries
- **Lack of coordination**. Insufficient communication between Medicaid and WIC, and among lactation and healthcare providers, MCOs, and community organizations

Elements of a Successful Lactation Support Program: Best Practices & Recommendations

This study also revealed numerous strategies and best practices to address these challenges. The following are recommendations for a successful lactation support program for Medicaid and CHIP beneficiaries:

- **Increase benefit awareness: Education about which lactation support services and breast pumps are covered, when and how they can be accessed.**
  - Facilitate culture change by enhancing education to beneficiaries, healthcare and social service providers, and community organizations about the benefits of breastfeeding.
  - Promote public/private efforts to inform beneficiaries, through Medicaid, health plans, medical providers, collaboratives, and community groups about lactation coverage and how to access the benefits.
  - Provide support and education to pregnant and postpartum Medicaid enrollees to support their breast pump selection, including establishing quality standards.

- Clarify and educate all stakeholders about when Medicaid or WIC is the primary source of services and pumps, or whether both sources are available (preferably to keep both channels open).
    - Provide a statewide list of lactation support providers and include lactation consultants/breastfeeding support as a searchable service/provider type in state and MCO provider directories.
    - Implement a state hotline connecting women to supports and guidance on how to access lactation services and breast pumps.
- **Expand benefits to offer more opportunities to access the services.**
    - Provide coverage for both mothers and infants.
    - Allow unlimited (or high limit on) lactation support visits in both individual and group settings.
    - Cover lactation support starting in the prenatal period (third trimester).
    - Cover one pump per pregnancy and allow access to a pump before the projected due date so the mother can become familiar with how it works before the baby arrives.
    - Cover breast pump replacement parts as well as milk storage bags.
    - Avoid prior authorization, prescription, medical necessity, and referral requirements, which result in hurdles and delays, for lactation consulting and manual/single-use electric pumps.
    - Prioritize access to double electric pumps, without required prior failure of a manual pump.
    - Cover home visits, peer counseling, and group appointments such as newborn classes.
    - Reimburse for support via telehealth/telemedicine, which can greatly expand access in rural areas (though internet challenges may exist), enabling a limited number of providers to reach more families, and addressing reluctance to having a stranger come into home.
- **Address billing, administrative, and reimbursement challenges.**
    - Establish clear, standardized CPT codes for lactation services that reflect the true value and scope of work performed by lactation consultants.
    - Reimburse for services at a sufficient rate, with differences that reflect training and scope of service.
    - Recognize IBCLCs as independent Medicaid provider types that can bill directly without supervision, with appropriate CPT codes.
    - Reimburse DME vendors sufficiently to ensure enough suppliers and to keep a variety of pumps on the shelves, avoiding delays and enhancing pump choice and quality for Medicaid beneficiaries.
- **Increase investment to expand workforce and address language/cultural barriers.**
    - Recognize lactation providers other than IBCLCs (requiring supervision when appropriate).
    - Provide guidance resources and streamline the process to apply as a Medicaid provider.
    - Invest to expand enrollment in lactation training programs for IBCLCs, CLCs, lactation educators, and peer consultants, through paid internships or apprenticeship pathways.
    - Promote recruitment and training of individuals who speak languages prevalent in local communities.

- **Enlist MCOs to promote breastfeeding.**
  - Include lactation support providers in provider directories.
  - Use multiple venues to educate members about the benefit.
  - Offer value-added benefits such as doulas (that provide lactation support), virtual and/or additional breastfeeding visits, lactation helpline with both English- and Spanish-speaking IBCLCs, and pump supplies.
- **Increase communication and collaboration across stakeholders.**
  - Promote a collaborative relationship between Medicaid and WIC, allowing for coordination and referrals when needed and reducing replication; WIC plays an important role in filling in gaps in Medicaid eligibility and in urgent situations, and assisting participants with an often-confusing process of accessing breast pumps through Medicaid or other insurance, underscoring the value of communication between WIC and Medicaid agency/MCOs.
- **Leverage maternal health collaboratives to maximize resources and outreach to enhance public awareness of the benefits of breastfeeding and how to access covered services and strengthen referral networks and cross-training.**
  - Seek input from multiple stakeholders during Medicaid lactation policy development, implementation, and on an ongoing basis to identify opportunities for improvement; communication among Medicaid, WIC, MCOs, community organizations, and providers to share challenges and solutions will result in improvements and a more successful lactation support program.

Implications for Future Policy

Comprehensive coverage for breastfeeding services and supports through Medicaid is a critical investment in the health and well-being of mothers, infants, and families. The recommendations in this report—spanning awareness, access, reimbursement, workforce development, and cross-system collaboration—highlight the need for a coordinated, equity-driven approach to translating coverage into meaningful care. Ensuring that these services are widely understood, easily accessed, and reliably delivered will require commitment from state agencies, MCOs, WIC programs, providers, and community partners alike.

In North Carolina, the upcoming procurement of Medicaid managed care Standard Plans presents a timely opportunity to embed stronger lactation and breast pump benefits into contracts and drive equitable access statewide. Nationally, the enactment of H.R. 1 further underscores the urgency of these reforms, as it shifts more fiscal responsibility to states. As states prepare for these financial shifts and tighter budgets, strengthening breastfeeding supports as a systems-level intervention could help states save Medicaid dollars by reducing healthcare utilization and associated costs.

Framing lactation services as both a health equity imperative and a cost-containment opportunity can help galvanize support for more robust policies. When fully integrated into Medicaid policy and practice, breastfeeding support can reduce health disparities, improve long-term outcomes, and provide essential support during one of life's most vulnerable and formative periods.

APPENDIX 1: MEDICAID BREASTFEEDING SERVICES INTERVIEW GUIDE

The following is a generic guide developed for Health Management Associates (HMA) interviews with key stakeholders. Prior to each interview, HMA tailored the guide based on the state's coverage policies for lactation services and breast pumps and the interviewee's specific role (state official, MCO representative, WIC representative, community group, lactation consultation provider, or other type of stakeholder). Depending on the number of individuals participating in each interview and the level of detail provided, not all questions were covered in each 60-minute interview.

Medicaid Breastfeeding Services Interview Guide – Generic for all Stakeholder Types

1. First, we'd like to confirm our understanding of how Medicaid beneficiaries access breast pumps in [State]. In preparing for this discussion, we reviewed [*list sources we used*]. Are there any other sources we should be looking at to identify key policies and resources?

    a. **Lactation Support Policy**

        i. Is lactation support a covered benefit?

            - [*If Medicaid expansion state*: Does coverage differ between the traditional Medicaid population and the Expansion population?]

        ii. Is there a benefit limit for lactation consultation services or other supports (e.g., number of appointments, availability prenatally?)

            - Is lactation consultation available only in hospital/at the bedside, or at home? Any other settings?
            - Is it covered in group settings? One-on-one?
            - Is lactation support covered if provided via telehealth?

        iii. Are there any requirements about the provider type(s) that are permitted to provide lactation support?

            - Are there Medicaid provider enrollment or licensure/ credentialing requirements? (e.g., must be a Medicaid-enrolled provider? International Board Certified Lactation Consultant (IBCLC)?)

    b. **Pumps and Supplies**

        i. Are breast pumps and supplies a covered benefit?

            - [*If Medicaid expansion state*: Does coverage differ between the traditional Medicaid population and the Expansion population?]

I. Prior authorization

- Is prior authorization required for breast pumps in your state Medicaid program? *[Tailor if policy is known]*
- Do you think prior authorization is an important utilization management tool for the provision of breast pumps? Why or why not?

iii. Prescription

- Is a prescription required for breast pumps in your state? *[Tailor if policy is known]*
- Do you think requiring a prescription is an important utilization management tool for the provision of breast pumps? Why or why not?

iv. Which pump types are covered under the Medicaid program (manual, electric, hospital-grade, single or double)? *[Tailor if policy is known]*

- Are there any rules/requirements for which type of pump the participant can receive?
- If so, what is the rationale behind those coverage rules? Are they beneficial or a barrier for the beneficiary?

v. Are there medical necessity criteria required for coverage of breast pumps in your state? *[Tailor if policy is known] If yes:*

- What are the medical necessity requirements?
- Do you think these medical necessity requirements are an important utilization management tool for the provision of breast pumps? Why or why not?

vi. Are there other utilization limitations for breast pumps and supplies in your state? If yes, what are they? *[Tailor if policy is known]*

- Do you think these limitations are an important tool to manage the breast pump benefit? Why or why not?

vii. What are the primary distribution channels for breast pumps for eligible Medicaid beneficiaries in your state (WIC, MCO, DME vendor)? *[Tailor if policy is known]*

- Has this approach been effective in enabling access to these supplies?

2. What is the state of access to breast pumps and lactation support for Medicaid beneficiaries?
    a. Are there any disparities in access (either by plan, region and/or population)?
    b. What is the lactation support workforce like? What needs are there? (Probe: language, culture, geography, availability, etc.)

3. Are there barriers or challenges **related to the coverage of or access to** lactation support or breast pumps and supplies?
    a. Barriers with coding and reimbursement?
    b. Barriers with provider enrollment (e.g., absence of a taxonomy code for lactation consultant during enrollment)?
    c. How are barriers or challenges related to these benefits communicated to regulators and/or payers?
        - Do you believe this process is effective?
        - Have they been responsive to feedback?
4. Do you conduct any targeted outreach to address challenges, barriers, disparities (e.g., language, geography, undocumented population)?
5. Do you monitor and/or collect data about how many members receive access to a breast pump and/or lactation support service utilization?
6. What is the reimbursement for lactation support? How does it vary by provider and/or payer?
    - Reimbursement via telehealth?

d. How is WIC involved in providing access to breast pumps, supplies, and lactation support?
    a. Have you experienced any challenges?
    b. How does WIC interact or coordinate with Medicaid for these services?

5. What are the opportunities to expand coverage of lactation support or breast pumps and supplies?
6. Any best practices or recommendations?

ENDNOTES

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